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HEALTH AND WELLBEING BOARD

Thursday, 11 December 2014 at 6.30 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Leader of the Council – Councillor Doug Taylor
Cabinet Member for Health and Adult Social Care – Councillor Donald McGowan (Chair)
Cabinet Member for Culture, Sport Youth and Localism – Councillor Rohini Simbodyal
Cabinet Member for Education, Children's Services and Protection – Councillor Ayfer Orhan
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer - Liz Wise
NHS England Representative – Dr Henrietta Hughes
Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Director of Schools and Children's Services – Andrew Fraser
Director of Environment – Ian Davis
Voluntary Sector Representatives: Vivien Giladi, Litsa Worrall (Deputy)

Non-Voting Members

Royal Free London NHS Trust – Kim Fleming
North Middlesex University Hospital NHS Trust – Julie Lowe
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright

AGENDA – PART 1

1. WELCOME AND APOLOGIES (6:30-6:35PM)

2. DECLARATION OF INTERESTS

Members are asked to declare any pecuniary, other pecuniary or non pecuniary interests relating to items on the agenda.

3. ANNUAL PUBLIC HEALTH REPORT 2014 - MIND THE GAP (6:35-7:00PM) (Pages 1 - 4)

To receive a report on the 2014 Annual Public Health Report "Mind the Gap: Reducing the Gap in Life Expectancy".

4. BETTER CARE FUND GOVERNANCE ARRANGEMENTS (7:00-7:25PM) (Pages 5 - 18)

To receive and agree a report with recommendations on the governance arrangements for the Better Care Fund.

5. PHARMACEUTICAL NEEDS ASSESSMENT (7:25-7:55PM) (Pages 19 - 22)

To receive an update on the development of a Pharmaceutical Needs Assessment.

6. SUB BOARD UPDATES (7:55-8:25PM) (Pages 23 - 92)

To receive the following updates from the sub boards:

a. Health Improvement Partnership Board
b. Joint Commissioning Board
c. Improving Primary Care Board

7. MINUTES OF MEETING HELD ON THURSDAY 16 OCTOBER 2014 (8:25-8:30PM) (Pages 93 - 104)

To receive and agree the minutes of the meeting held on Thursday 16 October 2014.

8. DATES OF FUTURE MEETINGS

To note the dates agreed for future meetings of the Board:

- Thursday 12 February 2015
- Tuesday 14 April 2015

To note the dates agreed for Board development sessions:

- Friday 16 January 2015
- Thursday 22 January 2015
- Thursday 12 March 2015

9. EXCLUSION OF PRESS AND PUBLIC

If necessary, to consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for any items of business moved to part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

(There is no part 2 agenda)

Agenda Item 3

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **11 December 2014**	**Agenda - Part: 1** | **Item: 3** **Subject: Annual Public Health Report 2014** **Wards: All**
Director of Public Health Contact officer : Tha Han 0208 379 1269 E mail: tha.han@enfield.gov.uk	**Approved by :** Shahed Ahmad

1. EXECUTIVE SUMMARY

1.1. One of the statutory duties of the Director of Public Health is to produce an Annual Public Health Report (APHR). This year's report is called **"Mind the Gap"** and focuses on reducing the gap in life expectancy in Enfield. The report is published in two versions, the short one for everyone and the long one for those who would like to see detailed information and data. The report outlines the evidence base of what works in tackling the life expectancy gap. It describes the evidence base generated by the National Support Team for Health Inequalities and the Marmot Report.

1.2. Chapter 6 of the report (please see long version) highlights the breadth of partners working to narrow the life expectancy gap in Enfield. In particular, the fact that in addition to the vast amount of excellent work being carried out by agencies and organisations based in Enfield, there are organisations based outside Enfield such as UCL Partners, British Heart Foundation, and Cancer Research UK who are also doing so much work in Enfield.

1.3. The focus of this year's report is on what works in the short term. In future, the focus of APHRs will be on the long term and the broader determinants of health. Next year's APHR will be on Child Poverty.

1.4. Since 2008, life expectancy at birth for males and females has improved by 1.3 and 1.1 years respectively. Enfield achieved lowest mortality rate for people under 75 when compared to our Public Health England Longer Lives peer group. More than 3,500 extra people in Enfield have had their blood pressure detected and controlled since 2008/09. This is thanks to the broad range of partnerships we have developed to tackle health inequalities by health, social care and voluntary sector.

1.5. The report identifies the need to broaden the focus to Enfield Lock, Chase, Jubilee and Ponders End.

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is asked to note the publication and the findings of the APHR

3. BACKGROUND

The APHR was produced by a project team in public health department. Partners are informed and statements are taken to include in some relevant chapters. This is a report by the Director of Public Health.

4. ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5. REASONS FOR RECOMMENDATIONS

Not applicable

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

Not applicable

6.2 Legal Implications

Not applicable

7. KEY RISKS

Not applicable

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

The APHR report meets the Health and Wellbeing Strategy priorities.

9. EQUALITIES IMPACT IMPLICATIONS

Not relevant but the report is aimed to reduce health inequalities

Background Papers

Short version:
http://www.enfield.gov.uk/downloads/file/10023/enfield_annual_public_health_report_2014_short_version

Long version:
http://www.enfield.gov.uk/downloads/file/10021/enfield_annual_public_health_report_2014

End of report.

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Agenda Item 4

MUNICIPAL YEAR 2014/15

MEETING TITLE AND DATE Health and Wellbeing Board 11th December 2014	**Agenda - Part: 1** **Item: 4** **Subject: Better Care Fund Update and Governance Arrangements** **Wards:** All
Chief Officer, Enfield CCG and Director of Health, Housing and Adult Social Care Contact officer Bindi Nagra E mail: bindi.nagra@enfield.gov.uk	**Consulted:** Cllr Don McGowan

1. EXECUTIVE SUMMARY

The Better Care Fund (BCF) is a national programme that will see the creation of a pooled budget made up of existing resources, to drive forward the further integration of health and care from April 2015/16. Councils and their CCG partners are asked to develop a joint plan that explains how each area will enhance the integration of Health and Social Care locally in order to access the fund. It also stipulates 'payment by performance' metrics in the reduction of emergency care episodes by 3.5% annually.

The HWB (HWB) at its meeting on 22nd of March 2014 approved the Enfield Joint BCF plan and the plan was submitted by the 4th of April deadline. A new submission was submitted on September 19th 2014 with the agreement of the Chair of the HWB, the Chair of the Clinical Commissioning Group (CCG) and the Leader of the Council.

The Better Care Fund Sub-Board and its Working Group were established by the HWB to develop an integrated system in Enfield and deliver the submission of the Joint Better Care Fund plan. The HWB now need to consider the governance structure going forward for the performance management and implementation of the joint BCF plan as well as for the financial governance, under Section 75, of the pooled BCF monies. This will need to be under the auspices of the HWB governance structure and in line with national guidance.

This report proposes two options for new governance arrangements and it is recommended that the HWB consider the options below and agree the governance structure for the Better Care fund set out in this paper.

Option 1 - a new Integration Board is established as a Sub Board of the HWB, operating with delegated powers from the HWB Board, to take forward the BCF plan and design a blueprint of what fully Integrated Services will be like across health and social care in Enfield. The new Board will replace the BCF Sub Board and its Working Group, and consolidate the Older Peoples Integration Board (which will be deleted).

Option 2 – a new Joint Commissioning and Better Care Board be established as a Sub Board of the HWB, operating without delegation, to take forward the implementation of the BCF plan and design a blue print of what fully Integrated Services will look like across health and social care in Enfield. The new Sub-Board will replace the current Joint Commissioning Board, the Integration Sub-Board and its Working Group (which will be deleted).

The chosen option will be supplemented and aided in decision making by the implementation of a Stakeholder Reference Group.

2. RECOMMENDATIONS

The HWB is asked to:

i. Agree either Option 1 or Option 2 and their associated remit and membership, for the governance of the Better Care Fund as set out in this report.

ii. Agree that LBE and ECCG explore wider opportunities for pooling their respective budgets under the integration agenda (as set out in section 3.4).

iii. Agree that the Terms of Reference (when agreed) and governance structure will be reviewed after six months of operation.

3. BACKGROUND

3.1 This report sets out proposed options for a new governance structure for the Joint Better Care Fund, as part of the wider integration agenda across Enfield. The new arrangements are intended to ensure strategic and operational oversight of the Better Care Fund locally, ensuring that programmes are delivered to time, within resources and meet the conditions as set out in national guidance. There is also a series of measures outlined around financial governance and the operation of a pooled budget across partner organisations. This new governance is also designed to reinforce the renewed emphasis on partnership working with local providers, that was expanded with the most recent BCF submission and to enable integration of health and social care across Enfield.

3.2 The ambition of much health and social care integrated working and commissioning is to shift the balance of resources from high cost secondary treatment (although the September BCF submission outlines 3.5% reduction in emergency care, the ambition for the medium to longer term is much greater than this) and long term care, to a focus on promotion of living healthy lives and wellbeing, and the extension of universal services away from high cost specialist services. This approach promotes quality of life and seeks peoples' and providers' engagement in their own community. To achieve these shifts, we need to change the way services are commissioned, managed and delivered. It also requires redesigning roles, changing the workforce and shifting investment to deliver agreed outcomes for people that are focussed on preventative action. This builds on existing arrangements between health and care already in place.

3.3 The Department of Health have produced guidance regarding the arrangements for managing the Better Care Fund pooled budget. A number of options are open to the CCG and Council (including Section 256 and Section 75 arrangements). The two partner organisations already operate a successful Section 75 agreement that covers the existing Joint Commissioning portfolio. A number of these arrangements will change as a result of the incorporation of the Better Care Fund.

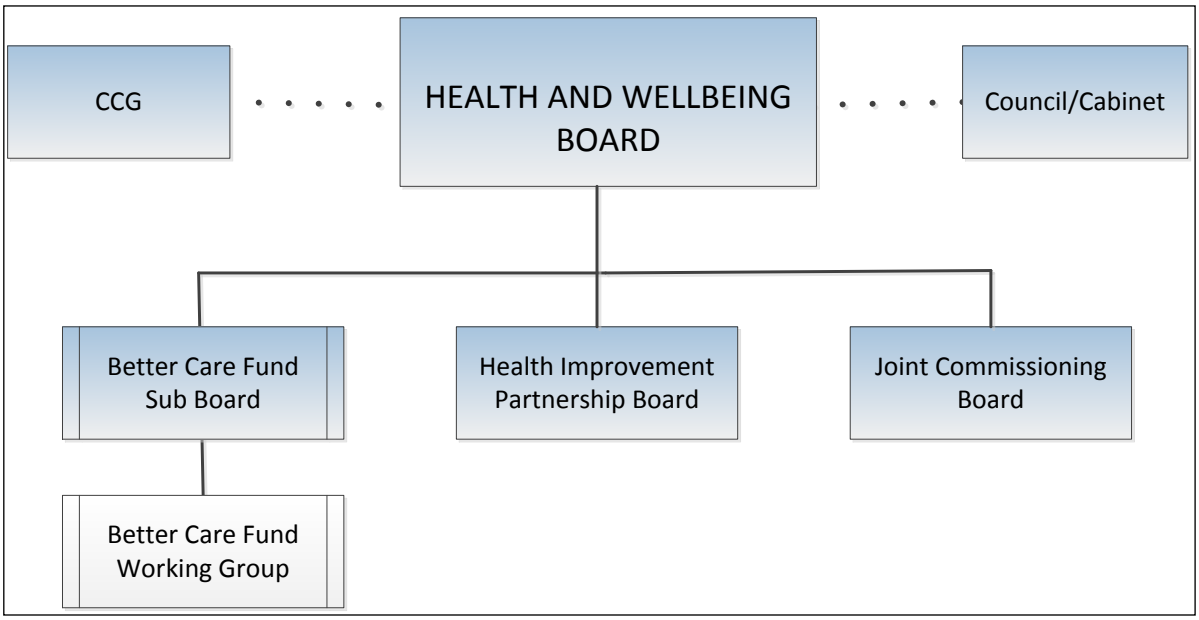
3.4 It is proposed to use the existing Section 75 agreement to manage the pooled budget for the Better Care Fund. This also provides the opportunity for the Council and the CCG to consider easily including within the BCF pool additional contributions including for example areas such as Continuing Health Care, Process, Intermediate Care and Public Health. Officers of the Council and CCG will continue to explore the opportunities to increase the range of activities included within the pool.

4. BETTER CARE FUND GOVERNANCE

4.1 The Current Arrangements

The current arrangements are based around a 'BCF Sub-Board' and it's 'Working Group' which were established by the HWB to develop an integrated system in Enfield and deliver the submission of the Joint Better Care Fund plan. This work is now largely complete and the HWB now needs to consider the governance structure going forward for the implementation and performance management of the joint BCF plan as well as for the financial governance (under Section 75), of the pooled BCF monies. Figure 1 below illustrates the current governance structure relating to the Better Care Fund.

Figure 1: Extract of HWB structure



Whilst the entirety of the governance structure beneath the Health & Wellbeing Board may need to be reviewed, this paper is solely concerned with the governance of the Better Care Fund and associated programmes of work.

4.2 THE OPTIONS

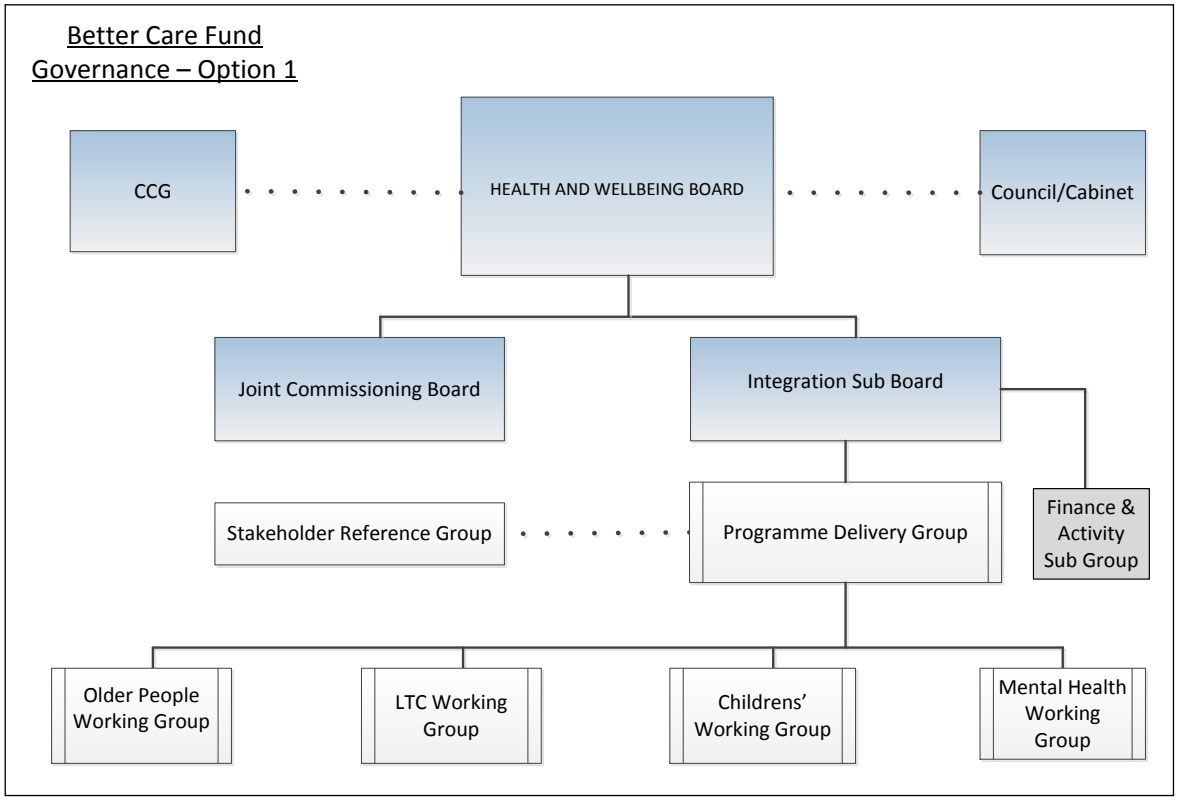
This section sets out the options for the new governance structures. Two options are proposed for consideration by the HWB and are set out below. Once agreed, the preferred option will be implemented with immediate effect. The two options are:

4.2.1 **Option 1**- a new Integration Sub-Board is established as a Sub Board of the HWB, operating with delegated powers from the HWB, to take forward the BCF plan and design a blueprint of what fully Integrated Services will be like across health and social care in Enfield. The new Sub-Board will replace the BCF Sub Board and its Working Group, and consolidate the Older Peoples Integration Board (which will be deleted).

Annex 1 (attached) sets out a Draft Remit and Membership of this Board Option. Full Terms of Reference will be developed and presented to the next business meeting of the HWB.

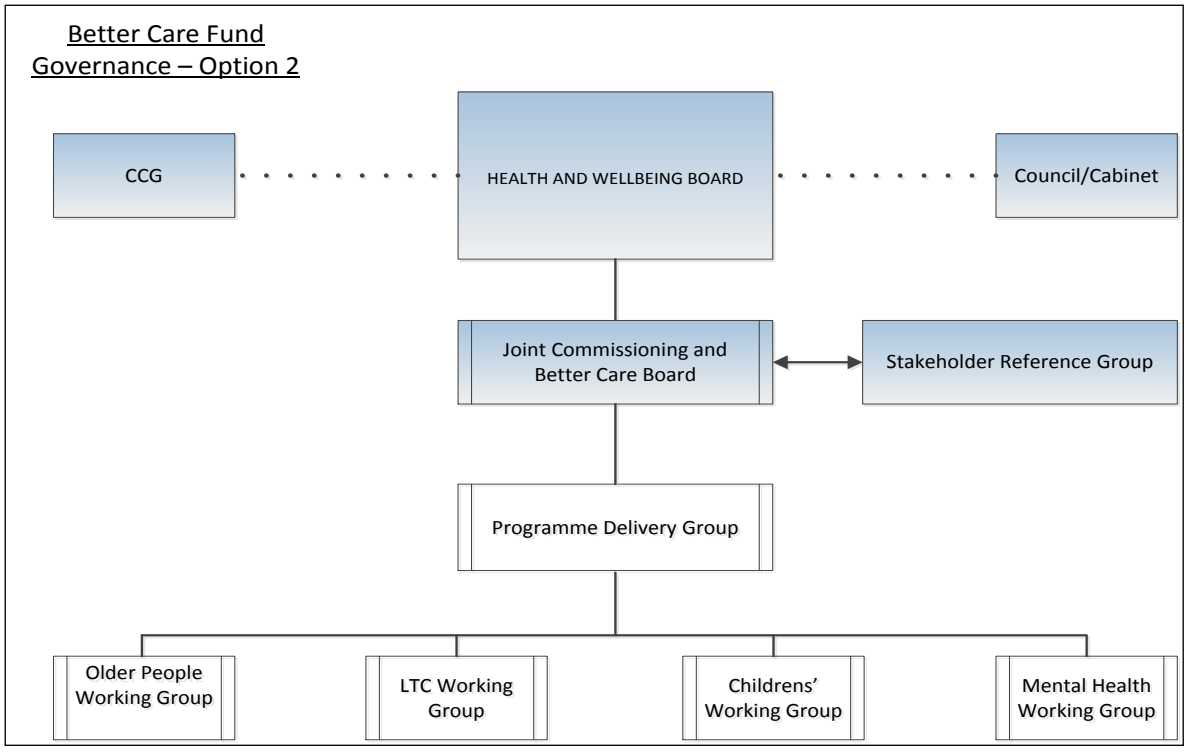
This Option is illustrated in Figure 2 below:

Figure 2: Proposed Governance Option 1:



4.2.2 **Option 2** – a new Joint Commissioning and Better Care Board be established as a Sub Board of the HWB, to take forward the implementation of the BCF plan and design a blue print of what fully Integrated Services will look like across health and social care in Enfield. The new Sub-Board will replace the current Joint Commissioning Board, the Integration Sub-Board and its Working Group (which will be deleted). Annex 2 (attached) sets out a Draft Remit and Membership of this Board Option. Full Terms of Reference will be developed and presented to the next business meeting of the HWB.

Figure 3: Proposed Governance Option 2:



4.2.3 The chosen new Sub-Board will meet monthly to provide appropriate levels of leadership with a view to shaping the integration agenda and overseeing implementation and delivery of the Joint Better Care Fund Plan. To ensure that the delivery of integration is happening at the pace and scale required, a Programme Delivery Group (PDG) will be established by the Sub Board and will set out the mechanisms for managing the BCF programme. The PDG will establish Working Groups to drive forward key programmes and engage providers and stakeholders where appropriate.

4.2.4 The chosen option will be supplemented and aided in decision making by the implementation of a Stakeholder Reference Group. Annex 3 contains draft Remit and Membership of the Group.

4.2.5 The HWB will remain the accountable body for the BCF Plan and Programme and any decisions outside of an agreed delegation of authority will need to be referred to the HWB. The Terms of Reference (when agreed) and governance structure will be reviewed after six months of operation.

4.3 OPTIONS APPRAISAL

Both options to be considered by the HWB have advantages and disadvantages in their selection. These are highlighted in the table below for consideration and to aid decision making by the HWB.

Option (s)	Description	Pros	Cons
Option 1	Establish an **Integration Board**	• Commissioning is bigger and broader than integration and should remain separate • Brings together key decision makers around Integration as well as BCF • Embeds the BCF in the whole system approach • Provides visibility across partner organisations • Powerful decision makers • Provides a clearer remit for JCB decisions • Resources can be jointly managed	• Leaves JCB as stand alone (and may need to be re-defined). • Will need to manage potential conflict of interests with providers
Option 2	Establish a new **Joint Commissioning and Better Care Board**	• Clearer remit than current JCB • Some potential synergies with joint commissioning function of BC	• Too big to be effective • Membership does have not enough vision for change • Conflict of interest with providers • Confusing commissioning with programme delivery aspirations

In light of the above appraisal, The BCF working group formed a view that option 1 was their preferred way forward.

It is important to note that although Enfield's health and care system has already identified and implemented opportunities for integration locally, we still need to take time to develop a definitive vision and blue print for the integration of the health and care system in its entirety. In view of this, it is important that the Executive Management Team from the CCG and the Council, under the auspices of the HWB, continue to meet on an ad-hoc basis to discuss the subject of integration in order to develop thinking; build partnerships and take time out to continue the process of understanding what a fully immersed and integrated system would look like; the benefits for the Enfield community and what the steps are to realise the vision.

5. ALTERNATIVE OPTIONS CONSIDERED

Do nothing – this is not a viable option and should not be considered. If we do not move forward with the integration agenda locally and implement our joint strategic plan as a partnership with governance arrangements that encourage and bolster our plans, then we are unable to deliver the efficiencies identified in our plan and maybe at risk of removal of the payment by performance element of the funding.

6 REASONS FOR RECOMMENDATIONS

We are recommending that the Better Care Fund Programme sits under the new governance Board selected by the HWB. The selected new Sub-Board will be part of the HWB governance structure.

7 COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

7.1 Financial Implications and Financial Governance

The Better Care Fund provides a sum of monies to be pooled between the LBE and CCG. Section 75 of the NHS Act 2006, allows local authorities and NHS bodies to operate pooled budgets (directly replacing section 31 of the Health Act 1999). The actual allocation of the BCF for the pooled budget in Enfield from 2015/16 will be £20.586m. The pooled budget will include plans to protect local social care services (£5.6m) and support unavoidable demographic/demand in growth for 2015/16 (the contingency of £1.5m).

Plans for the use of the pooled monies have been agreed between NHS Enfield CCG and the Local Authority and approved and signed off by each of these parties and Enfield's HWB in September 2014. To access the BCF, these local plans set out how the pooled funding will be used and the ways in which the national and locally agreed targets attached to the performance-related element of the funding will be met.

The Enfield Better Care Fund Programme is to be managed via the Section 75 regulations and a draft schedule of the Section 75 Schedule will be brought to the next business meeting of the H&WBB. The HWB will also consider wider opportunities for integration and explore the additional pooling of LBE and CCG budgets in the coming months.

8 LEGAL IMPLICATIONS

8.1 Under section 195(1) of the Health and Social Care Act 2012, there is a duty on a HWB to 'encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner', for the purpose of 'advancing the health and wellbeing of the people in its area'.

The Local Authority (Public Health, HWBs and Health Scrutiny) Regulations 2013 govern the functioning of the HWB. Regulation 3 (2) amends Section 101(2) of the Local Government Act 1970 to read: **'**Where any functions may be discharged by a HWB by virtue of any enactment, other than section 196(2) of the 2012 Act (other functions of HWBs) then, unless the local authority which established the Board otherwise directs, the Board may arrange for the discharge of any of those functions by a sub-committee of the Board.'

The proposals set out in this report would appear to fall within the above provisions.

The Better Care Fund (BCF) Frequently Asked Questions guidance notes that have been issued by NHS England states that 'the accountable body will be the organisation from where the money originated, but the existing statutory section 75 arrangements will still apply for the delivery of services.'

9 KEY RISKS

9.1 The full risk register contained within the BCF plan and previously agreed by HWB, has been uploaded to the Council's risk management programme and will be managed by the chosen sub board.

10 IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

10.1 Healthy Start – Improving Child Health

The main thrust of the BCF is to integrate health and care further which will have a positive impact on the whole health and social care economy in Enfield.

10.2 Narrowing the Gap – reducing health inequalities

The BCF is a means to ensure closer working between health and social care so that adults living in the Enfield community are offered a range of services to keep them well and healthy in their own home or in a community setting, including those with long term conditions.

10.3 Healthy Lifestyles/healthy choices

Further integration of health and care services will produce better outcomes for people living in the Enfield community. It will ensure that people are at the heart of decision making with health and social care outcomes that are focused on keeping people healthy and well in the community. In particular, it asks that health and social care services are co-ordinated around the individual.

10.4 Healthy Places

By working in partnership, the BCF will ensure that we make Enfield a healthier place and address health inequalities faced by our adults living in the community.

10.5 Strengthening Partnerships and Capacity

Development of the BCF is an opportunity for closer working between health and social care and our partners holistically across the economy of Enfield. It calls for clear leadership, accountability and assurance so that the partnership works for the benefit of all adults. We are being asked to commission and work in an integrated way. This will of course strengthen partnerships and capacity to deliver services that meet the need of our adults living in the community.

11 EQUALITIES IMPACT IMPLICATIONS

Equalities Impact Assessments will need to be undertaken as necessary at the point of any service reconfigurations or planned changes.

12. PERFORMANCE MANAGEMENT IMPLICATIONS

12.1 As defined by the conditions of the BCF, we are developing a performance framework that is focussed on understanding our baseline in terms of key activity and developing an outcomes framework to focus activity that promotes choice, control, empowerment, reablement, recovery, self-resilience and independence.

ANNEX 1 - Draft Remit and Membership – Integration Board

The Integration Board will act as the key management body for the BCF and Integrated Care programmes and will operate with delegated powers from the HWB. Any decisions outside the terms of the delegated authority will require a formal decisions being subject to ratification by the HWB.

The Integration Board will act as a formal sub-board of the HWB and will have delegated powers to manage the programmes within the budget and programme limits set by the HWB up to a financial value of £250,000. Any decisions above this limit will require to be referred to the HWB.

A 'Finance & Activity Sub-Group' of the Board will be established. The Integration Board will determine these functions.

Key Responsibilities:

- Managing the BCF and integrated Care Programmes
- Delivering and Owning the Vision for Integrated Care
- Communicating the Vision for Integrated Care
- Defining and owning the blueprint for change
- Responsibility for defining and managing the overarching Risk Framework
- Managing by exception the identified Critical Success Factors, benefits and Milestones of the BCF Programmes
- Providing 'whole system' leadership in the oversight & development of integrated Care
- Providing Financial, Quality and Risk Management leadership (subject to delegated authority from the HWB)
- Owning the 'desired outcomes' (end states), benefits and value for Enfield's people and monitoring them in light of safeguarding and quality of care considerations
- Providing regular reporting and monitoring information to the HWB Board particularly where there are perceived high level risks and issues for delivery
- Monitoring the benefits realisation and delivery milestones, via highlight reports, within the Better Care Fund programme and Integrated Care Programmes
- Leading the programme of work through facilitating and developing a positive culture across organisations for improved service integration for those populations identified through the joint Better Care Fund plan
- Individually and jointly communicating key messages across staff partners/people - including supporting the communications campaign and strategy
- Identifying and ratifying quick and sustainable opportunities for further integration of services across Enfield
- Unblocking of any actual or potential barriers to success in partner organisations
- Jointly engaging with stakeholders (both internal and external) in development and implementation of the Programme to ensure awareness and ownership
- Ensuring that appropriate community engagement is taking place and feedback is captured and acted upon swiftly.

Draft Membership of Integration Board

The Board will comprise of a mixture of representatives from NHS and Local Authority commissioning and provider organisations. However, in line with the HWB constitution, Provider representatives shall be members of the Board but not have voting rights.

Chair and voting

The Chair of the Integration Board will be the Chair of the CCG. The Chair will provide regular updates to the HWB. Members of the Board shall have one vote. Decisions will be made by the majority.

Consideration will need to be given to how the Integration Board will share information with the Joint Commissioning Board, Value Based Commissioning, the Council's Transformation Board, Leaner 2017 programmes of work and the CCG's Transformation Programme Group. Consideration will need to be given to how the BCF and Integration Board will share information with other governance arrangements already in place across both LBE and ECCG.

Voting Members

Title	Organisation
CCG Chair (Chair)	ECCG
Director of Health, Housing and Adult Social Care	LBE
CCG Chief Officer	ECCG
Chair	Healthwatch Enfield
Director of Schools and Children's Services	LBE

Non-Voting Members

Title	Organisation
Chief Executive – Royal Free Hospital NHS FT	NHS
Chief Executive – North Middlesex NHS Trust	NHS
Chief Executive - BEH-MHT	NHS
Primary Care Provider Representatives (X2)	NHS
Assistant Director, Adult Social Care - HHASC	LBE
Integration Programme Director (BCF Programme Manager)	CCG/LBE
Assistant Director Strategy and Resources - HHASC	LBE
Director of Strategy and Partnerships	ECCG
Chief Finance Officer	ECCG
Director of Finance	LBE

Reporting

The Integration Board will receive updates from the Programme Delivery Board (which is chaired by the Integration Programme Director) and, in turn, provide updates to the HWB. Individual members will be responsible for updating their own organisations on progress. The Board will establish Working Groups to drive forward key programmes and engage providers and stakeholders where appropriate.

Conflicts of Interest

Given the stated aim of integrated services, it is essential that the perspectives, experience and expertise from all parties is welcomed and encouraged during discussions. However, in some cases, members of the Integrated Board will have a conflict of interest. In such cases it is proposed that:

- Where there is a direct interest (or Direct Pecuniary Interest) then the board member should declare that interest and take no further part in the discussion.
- Where there is an interest which is not a direct financial or contractual interest, e.g. a non-pecuniary interest, then the board member should declare that interest and is permitted to remain in the meeting and participate in the discussion.

Review

The Terms of Reference (when agreed) and governance structure will be reviewed after six months of operation.

ANNEX 2 – Draft Remit and Membership – Joint Commissioning and Better Care Board

Remit

The Board will act as the key advisory body for the Integrated Care Programme, without delegation and with any formal decisions being subject to ratification by the HWB, by:

- Leading and performance managing the delivery of the Better Care Fund 2 year strategic plan.
- Providing Financial, Quality and Risk Management leadership (subject to ratification from the HWB)
- Owning the 'desired outcomes' (end states), benefits and value for Enfield's people and monitoring them in light of safeguarding and commissioning and quality of care considerations
- Ensuring a co-ordinated approach across health and social care commissioning (inc. Public Health) in partnership with the Clinical Commissioning Group and particular reference to BCF commissioned services.
- Leading on the development and implementation of integrated care pathways for agreed conditions in order to reduce bureaucracy and overlaps in integration
- Monitoring implementation of joint commissioning strategies (Stroke, Dementia, Intermediate Care and Re-ablement, and End of Life Care) and receive reports on the development of new joint Strategies (for example, Autism, Mental Health, and Carers).
- Providing leadership and guidance on certain agreed commissioning intentions set out in Joint Commissioning Strategies and the BCF Programme
- Monitoring performance of jointly commissioned services and highlighting cost pressures or risks as they arise.
- Ensuring that robust integrated performance management systems across health and social care are developed that enable the programme to monitor quality, outcomes and expenditure. The initial focus will be on ensuring integrated performance frameworks that measure the impact of joint commissioning strategy implementation are in place.
- Reporting through the Chair to the HWB and CCG on the performance of jointly commissioned services, the further development of integrated services and pathways, and the implementation and development of joint commissioning strategies under the BCF Programme.

Membership

Title	**Organisation**
CCG Chief Officer	CCG (Chair)
CCG Clinical Lead	CCG
Director of Health, Housing and Adult Social Care	LBE
Assistant Director of Strategy and Resources	LBE
Director of Strategy and Partnerships	CCG

Assistant Director - Commissioning & Community Engagement, Schools and Children's Services	LBE
Chief Finance Officer	ECCG
Director of Finance	LBE
Assistant Director of Public Health	LBE
Head of Commissioning, Procurement, Contracting and Brokerage	LBE
CCG Board Member (Mental Health lead)	CCG
CCG Board Member (Children's lead)	CCG
Primary Care Provider Representatives (X2)	NHS
Head of Mental Health Commissioning	CCG
Head of Children's Commissioning	CCG
Better Care Programme Manager	CCG/LBE

Reporting

The Joint Commissioning and Better Care Board will receive updates from the Integration Programme Board chaired by the Better Care Fund Programme Manager and, in turn, provide updates to the HWB. Individual members will be responsible for updating their own organisations on progress.

The Board will establish Working Groups to drive forward key programmes and engage providers and stakeholders where appropriate.

Chair and voting:

The Chair is the Chief Officer from the CCG. The Chair will provide regular updates to the HWB. Members of the Board shall have one vote and decisions will be made by the majority. Consideration will need to be given to how the Board will share information with the Joint Commissioning Board, Value Based Commissioning, the Council's Transformation Board and Leaner 2017 programmes of work.

Review

The Terms of Reference (when agreed) and governance structure will be reviewed after six months of operation.

ANNEX 3 – Draft Remit and Membership of Stakeholder Reference Group

Remit

- To review, make comments and recommendations regarding the service models developed by the programmes
- To provide a source of professional expertise/assurance available across the programmes.
- Suggest, assure and recommend delivery models for approval in the members' Statutory Organisations
- Ensure active Professional Leadership supporting the agreed service models from all partner organisations
- Ensure that the workstreams and programmes provide appropriate designs and products consistent with the overall clinical models of the Plan
- Test and provide assurance for proposed service changes to understand their appropriateness in meeting the agreed vision for Integration

Membership

Title	Organisation
Chair	ECCG
Chair	Healthwatch Enfield
Medical Director - Royal Free Hospital NHS FT	NHS
Director – Strategy and partnerships	ECCG
Assistant Director - Commissioning & Community Engagement, Schools and Children's Services	LBE
Assistant Director – Strategy and Resources	LBE
Medical Director – North Middlesex NHS Trust	NHS
Medical Director – BEH - MHT	NHS
Director of Public Health	LBE
Better Care Fund Programme Manager	CCG/LBE
Senior Practitioner (Social Care)	LBE
Primary Care Provider Representatives (X2)	NHS
Third Sector Representative	EVA

Agenda Item 5

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **11 December 2014**	**Agenda - Part: 1** **Item: 5** **Subject:** **Pharmaceutical Needs Assessment** **Wards:All**
Report of: Dr Shahed Ahmad Director of Public Health	**Cabinet Member consulted:**
Contact Officer: Allison Duggal: 020 8379 2894 E mail: Allison.Duggal@enfield.gov.uk	**Approved by:**

1. EXECUTIVE SUMMARY

- Enfield Health and Wellbeing Board (HWB) has a statutory duty to produce a Pharmaceutical Needs Assessment (PNA) by 1 April 2015
- The PNA is a statement of needs for pharmaceutical service provision within the HWB area.
- The PNA will be used by NHS England to determine applications from providers to provide pharmaceutical services. In addition, it will be used by CCGs and the local authority to consider services that may be provided from pharmaceutical service providers to reduce inequalities, improve access, and improve the health and wellbeing of the population
- The HWB have delegated the responsibility to oversee the production of the PNA to a Steering Group chaired by a Consultant in Public Health.

2. RECOMMENDATIONS

- The HWB is asked to note the points in this paper

3. BACKGROUND

Background

- Enfield Health and Wellbeing Board (HWB) has a statutory duty to produce a Pharmaceutical Needs Assessment (PNA) by 1 April 2015
- The PNA is a statement of needs for pharmaceutical service provision within the HWB area.
- Pharmaceutical services include the majority of services provided by community pharmacies, as well as dispensing providing from dispensing GP practices and appliance contractors
- The PNA will be used by NHS England to determine applications from providers to provide pharmaceutical services. In addition, it will be used by CCGs and the local authority to consider services that may be provided from pharmaceutical service providers to reduce inequalities, improve access, and improve the health and wellbeing of the population
- The HWB have delegated the responsibility to oversee the production of the PNA to a Steering Group
- Writing of the PNA has been outsourced to a specialist company, Soar Beyond, following a procurement earlier this year

Steering Group (SG)

- The SG is chaired by Allison Duggal, Consultant in Public Health
- The SG is made up of representatives from Enfield Council, Enfield Healthwatch, Middlesex Pharmaceutical group, NHS England and Enfield CCG
- Members of the SG have been chosen because of their local knowledge, representation, and experience in previous PNA productions
- The SG has met to discuss, plan and progress for the development of the PNA
- Terms of Reference for the SG have been agreed. The main role of the SG is to facilitate the production of the PNA, which is being led by the Chair
- In addition to the SG, a series of web and telephone meetings have been planned between the SG Chair and the project team in Soar Beyond

Draft PNA production

- The production of the Draft PNA includes the collation of pharmacy service provision (provided by NHS England), and public health data (provided by Enfield Council)
- A timeline for the production of the Draft PNA was agreed by the Steering Group
- The draft PNA has now been produced and, after discussions at the last Steering Group meeting, will be going out for wider consultation on the 1 December.

Consultation

- The 2013 Pharmaceutical Regulations, covering the PNA's production, include a requirement to consult for 60 days on the Draft PNA; this has been proposed by the SG to be conducted between 1st December 2014 and 31st January 2015.
- It is planned for the final PNA to be presented at the HWB meeting on 12th March 2015, following completion of the consultation and consideration of the responses
- The HWB will be asked to approve the final PNA for publication to meet our statutory obligations.

4. ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5. REASONS FOR RECOMMENDATIONS

The pharmaceutical needs assessment needs to be consulted on for 60 days and will be brought to the WHB for final sign-off in March 2015 before publication.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

There are no financial implications as a result of producing a Pharmaceutical Needs Assessment (PNA), however as a result of the PNA, should there be additional expenditure incurred to reduce inequalities, improve access, and improve the health and wellbeing of the population, this will have to contained within the existing Public Health grant.

6.2 Legal Implications

Section 128A of the National Health Service Act 2006 requires every Health and Wellbeing Board to assess pharmaceutical need in its area, and publish a pharmaceutical needs assessment.

Regulation 5 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ('the Regulations') requires each Health and Wellbeing Board to publish its Pharmaceutical Needs Assessment by 1 April 2015. The Regulations set out requirements for contents of the Assessment, consultation, and matters to be considered.

The matters set out in this report comply with the above requirements.

7. KEY RISKS

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life
8.2 Enabling people to be safe, independent and well and delivering high quality health and care services
8.3 Creating stronger, healthier communities
8.4 Reducing health inequalities – narrowing the gap in life expectancy
8.5 Promoting healthy lifestyles

The provision of good quality pharmaceutical services for the population of Enfield contributes to all of the priorities of the Health and Wellbeing Board.

9. EQUALITIES IMPACT IMPLICATIONS

There is an Equalities Impact Analysis (EqIA) in development for this needs assessment.

Background Papers

- Draft pharmaceutical needs assessment can be found via the link below:

  www.enfield.gov.uk/pna_consultation

Agenda Item 6

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE
Health and Wellbeing Board
11 December 2014

Agenda - Part: 1	**Item: 6a**
Subject: Health Improvement Partnership Board Update Report – Nov 2014 **Wards:**	
Cabinet Member consulted:	
Approved by: Shahed Ahmed	

Dr Shahed Ahmed
Director of Public Health
shahed.ahmad@enfield.gov.uk
0208 379 3737

1. EXECUTIVE SUMMARY

This report updates the Health and Wellbeing Board on work of the Health Improvement Partnership Board

2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board note the content of this report.

3. HILO PROJECT

Page 166 of the Annual Public Health Report describes the work with UCL Partners and page 178 describes the Hilo project which was part of this and delivered by QMUL. This project has worked with 2 practices (in Edmonton and Ponders End). Within a 9 month period , for 1000 or so patients whose blood pressures and cholesterol levels had been hard to control, this project has led to a 10mmHg drop in BP and a 0.5mmol/l drop in cholesterol. These results are fantastic and will certainly reduce the mortality rates in this group and PHE intend to showcase this nationally.

4. CHILD POVERTY CONFERENCE

This was held on 17th November at the Dugdale Centre. A steering group, organised a conference for 100 delegates from different organisations and stakeholder groups. Delegates included people from Enfield Council , voluntary sector, GLA, Public Health England, 4 Children and all local NHS organisations including three Chief Executives. Initial feedback was

broadly positive and there was certainly an enormous amount of positive energy in the room. Actions have been suggested to the steering group to be included in the overall action plan.

The conference will be evaluated and there will be post conference communications. A delivery group will take forward the action plan.

5. INDIVIDUAL FUNDING REQUESTS (IFRs)

IFRs are requests for medical interventions that fall outside provider contracts. Four IFRs have been received since September. All IFRs are up to date.

6. EMERGENCY PLANNING / PANDEMIC FLU

Public Health has led on the production of a borough-wide pandemic influenza plan. This details how the Council would work with partners to respond to pandemic influenza and will be presented to the next Borough Resilience Forum for ratification.

7. BREASTFEEDING SUPPORT

The Breastfeeding peer support training contract has been signed and work will commence this month. 12 Peer supporters have been recruited to undertake an intensive training course organised by the National Childbirth Trust. They will be ready to take up one year placements in the different Children's centres by February 2015.

The campaign to enrol more businesses to the Breastfeeding Welcome scheme is still on going and to date 91 businesses have registered.

Work with Wirral Community NHS Trust is in progress, to develop a breastfeeding application which will enhance access to information about breastfeeding, support available and all the businesses that welcome breastfeeding on their premises in Enfield. This will be a useful tool in targeting young parents and we hope to develop it for other health promotion messages in future.

8. EARLY ACCESS TO MATERNITY

A DVD has been developed based on research with communities who are booking in late to address their concerns, allay fears and encourage them to book earlier. This was based on the outcomes of a joint venture with Haringey, where African women in Haringey and Enfield gave their views on the issues around early access to maternity.

9. PHARMACEUTICAL NEEDS ASSESSMENT

The pharmaceutical needs assessment is progressing according to the project plan. The first draft is now ready and will be presented to the PNA steering group on 20th November 2014. Formal consultation on the draft will commence on 1st December 2014 and finish on 31st January 2015.

The final draft will be submitted to the Health and Wellbeing Board on 15th March 2015. The PNA Steering group meets quarterly and two meetings have been held to date.

10. FEMALE GENITAL MUTILATION

Work on the FGM needs assessment continues and an initial paper was presented at the Enfield Safeguarding Children's board on 24 November. There are many strands of work across the council and community to address the issue of FGM and Public Health continues to chair the Enfield Safeguarding Children's Board's task and finish group on FGM, co-ordinating health promotion, awareness raising and training around FGM. In addition, the adequacy and quality of local services for victims of FGM in the borough are being considered. An interim protocol for professionals dealing with women at risk of, or victims of, FGM has been agreed and is in use by local healthcare professionals. Initial findings are:

- FGM is associated with severe mental and physical health problems and is illegal in the UK. It is illegal to perform FGM in the UK and illegal to take a girl out of the country for the purposes of FGM.
- As an ethnically diverse borough, Enfield has a number of communities where FGM is prevalent. The prevalence of FGM can vary between countries from almost zero to 98% of women.
- There are an estimated 2823 girls and young women at risk of FGM in Enfield.

11. CHILD DEATH OVERVIEW PANEL (CDOP)

The consultant for children and young people's public health chairs of the Child Death Overview Panel and has drafted an annual report for the Enfield Safeguarding Children's Board. There is a meeting planned for December at which further development of CDOP will be discussed, along with plans for a number of initiatives to reduce infant mortality and child death in the borough.

12. SCHOOL NURSING CONTRACT AND HEALTH VISITOR MIGRATION

The school nursing contract specification is being finalised for procurement in 2015/16.

Work is ongoing to prepare for the transition of health visiting (HV) and Family Nurse Partnership (FNP) to the local authority in 2015. This has included discussions with NHS England (London) and London Councils.

13. HEALTH PROTECTION FORUM

The Enfield health protection forum (e.g. infection control and environmental hazards) is planning to meet in December. This group

oversees a 'joined-up' approach to health protection actions and emergency planning in the borough.

Topics at the next meeting with include immunisation rates, Ebola, Scarlet Fever and pandemic influenza planning.

14. WORK WITH THE CCG

Public Health, as mandated, continues to support the NHS Enfield CCG with health intelligence and clinical evidence to ensure improvement in population health and effective healthcare. Annual Public Health Report also adds value to this support. Following publication of the APHR , practice profiles have been produced for every GP practice in Enfield and handed over to the CCG.

15. BETTER CARE FUND (BCF)

Public Health has been supporting the CCG & Council commissioning plans to develop and implement the Better Care Fund.

16. MEDIA CAMPAIGNS

Antibiotics campaign: Public health produced a report on appropriate antibiotics use and is coordinating a campaign with cooperation from the CCG, local infection control teams, GPs and pharmacists. European antibiotics awareness day is on 18 November 2014.

Hypertension: We recently ran a hypertension awareness campaign. This involved the display of a number of information designs as fixed posters in a variety of settings, including hospital, surgeries and council facilities as well as at bus stops, on the buses and other street sites. We believe that PHE have circulated this as an example of best practice to their PHE centres nationally.

17. COMMUNITY EVENTS

Hypertension awareness conference was organised by Stroke Action in Edmonton Green.

18. FOOD PARTNERSHIPS

We invited Jonathon Pauling, Food Policy lead at the GLA to contribute to a Food partnership workshop.

The Enfield Food Partnership is a group of organisations, joining together to discuss current issues and to bring together the diverse elements of the food, health, environment and economic sectors in order to encourage a more sustainable food system throughout the Borough.

The partnership currently has 36 members from across Enfield, representing a broad range of sectors, including statutory and voluntary sector, business, and community and individual residents.

The Partnership is focusing on six key food issues, including:

1. Promoting healthy and sustainable food to the public
2. Tackling food poverty and increasing access to affordable healthy food
3. Building community food knowledge, skills, resources and projects
4. Promoting a vibrant and diverse sustainable food economy
5. Transforming catering and food procurement
6. Reducing waste and the ecological footprint of the food system

Terms of reference and a local action plan are currently in development and once agreed, the Enfield Food Partnership will apply to become a member of the national Sustainable Food Cities Network. This is expected by early Spring 2015.

19.1 SMOKING

Enfield achieved and exceeded its smoking target for 2013-14; 1707 four-week quitters were achieved against a target of 1572.

Q1 achievement was 279 quitters against a target of 270. Q2 data will not be available until 9th December 2014. This follows the same trajectory as last year (most smoking quitters are achieved in Q4 due to New Year quitters and National No-smoking day, see below).

19.2 STOPTOBER, NEW YEAR AND NATIONAL NO-SMOKING DAY

Enfield ran a number of events for Stoptober including publicity events in the Town Centre and a comedy night for smokers at the Dugdale centre.

We are currently preparing for the New Year and National No-Smoking day (11th March, always the second Wednesday in March). We are negotiating with the CCG to text every registered smoker through IPlato.

Public Health also presented at two GP protected learning times (PLTs) on cancer where the main prevention message was to stop people smoking.

19.3 TOBACCO CONTROL

PH and the CE directorate commissioned a report on smoking in the Turkish community. Draft findings include that smoking prevalence in this community remains at approximately 50% (following a similar finding across London in 2004), that smoking can be through a variety of methods; cigarettes, shisha, roll-ups and cannabis and that shisha is viewed quite differently to cigarettes e.g. condoned and even encouraged

by parents. This was presented to the Strategic Leadership Forum on 10th November for discussion / comment and will be taken forward with and through the Tobacco Control Alliance.

Smoking prevalence results have just come out. Enfield is now at 15.8%, which is about the same as New York. This is quite an extraordinary achievement.

20. HEALTHCHECKS

Enfield delivered 1, 825 healthchecks in Q1 and 1,778 healthchecks in Q2 (half-year total of 3603).

21. SUPPORT FOR NATIONAL AND PAN LONDON WORK

We have been supporting Ged Curran CEO of Merton Council develop plans for local government supporting primary care co-commissioning and have been supporting Ealing Council CEO , Martin Smith's London Integrated Care Group and have supported the London Primary Care Transformation Board. At a national level we supported the Blood Pressure Systems Leadership Group produce the document released on November 18th "Tackling High Blood Pressure, from evidence to action" , have been helping draft the dementia and equity plan and have contributed at the HSJ summit, and in particular helped ensure NHS kept a focus on prevention, children and health and wellbeing boards.

One of our Consultants sat on an expert panel at the ukactive national conference on physical activity on 13th November.

22. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

22.1 FINANCIAL IMPLICATIONS

There are no financial implications as this report is for information only.

22.2 LEGAL IMPLICATIONS

There are no legal implications as this report is for information only.

23. KEY RISKS

There are no risks as this report is for information only.

24. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

There are no impacts on the priorities of the Health and Wellbeing Strategy as this report is for information only.

25. EQUALITIES IMPACT IMPLICATIONS

There are no Equality Impact Implications as this report is for information only.

Background Papers

There are no background papers.

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Agenda – Part: 1	Item: 6b
Subject: Joint Commissioning Sub Board Update Report	

Health and Wellbeing Board
Thursday 11th December 2014

REPORT OF:

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1. EXECUTIVE SUMMARY

1.1 This report provides an update on the work of joint commissioning across health and social care in Enfield.

1.2 Updates for all key commissioning areas are included, as are relevant updates on commissioning activity from Partnership Boards.

1.3 This report notes:

- Progress regarding implementation of the Care Act 2014
- The Better Care Fund was approved "…with support…". The Better Care Plan does not require re-submission but we do need to provide additional evidence. Once the HWB has determined the governance structure for BCF (see separate report), both LBE and ECCG will be required to publish the BCF plan on their respective websites in order to achieve full approval.
- Enfield's Integrated Care Programme for Older People section outlines the structure of the integrated care pathway for 2014/15 and 2015/16, linking the Better Care Fund Plan to the delivery mechanism of the programme.
- The Council is currently reviewing its options regarding the procurement of Sexual Health and School Nursing services, in respect of the Enfield Community Services Procurement Programme that has been postponed by the CCG.
- The contribution from the Head of Primary Care, NHS England regarding Co-Commissioning
- Adult Social Care has agreed to fund the 2014/15 'Keep Warm, Keep Safe' programme.
- The finalisation of Enfield's Joint Autism Framework, which will be published on the Council and CCG websites.

1. EXECUTIVE SUMMARY (CONTINUED)

- The Council and CCG's joint programme – Transforming Care for People with learning disabilities (Winterbourne View), highlighting the improvements made since the last H&WB paper

- The success of the Community Intervention Service for people with complex needs that has attributed to reducing the numbers of admissions to our in-borough assessment and treatment service

- The increase in registration of new Carers within the borough; the introduction of the respite programme and recruitment of a Benefits Advisor.

- Whilst DAAT's performance against successful treatment completions has shown a slight decline for the 12-month rolling data (sept 2013 – Aug 2014), the results still show Enfield above the London and National averages

- The commissioning of the evaluation of the Making Safeguarding Personal programme

- The positive feedback from the two-week intensive visit Quality Checker programme to four libraries

- The Improving Residents' Lives sub-group action plan has been approved for action. Care home manager leads and the process of hospital discharges into care homes has been identified as areas for improvement

- The agreement for a Multi-Agency Safeguarding Hub (MASH) for vulnerable adults, which will fit with the MASH currently in place for children, will be located within space currently occupied by the children's SPOE as part of the Enfield 2017 transformation programme from 01 April 2015.

- Planning permission for the development of 14 homes providing specialist housing with care for older people with learning disabilities has been granted to Newlon Housing Trust

- The appointment of Haverstock Health as the new GP provider and Whittington Health as the community dentist for the Ordnance Unity Centre

- Board updates

3. THE CARE ACT 2014

The implementation of the Care Act 2014 is well underway. Progress has been made in a number of key areas with a focus on the reforms due in April 2015. This progress includes a range of activities across the work streams as follows:

- **Market and Community Customer** – this includes the new duties for local authorities for the provision of Information and Advice. A comprehensive gap analysis has been produced and a review of the implications of the Care

Act for commissioning, procurement and contracting arrangements. Other activities include a market failure and provider exit strategy, Self-funders research and a refresh of market position statement

- **Finance and Risk Management** – a range of national financial tools has been completed and a local model developed. This is work in progress and assumptions are currently being tested. Consultation on the Dilnot reforms is due in February 2015, in preparation for the funding reforms in April 2016

- **Workforce Capacity and Development** – a number of briefings have been delivered and an e-learning module is currently being designed and will be available in January. Further focused development tools and events are planned.

- **Communications and Engagement** – a range of activities have taken place and planned including a Reference group of local people established, a Care Act webpage set up on the Council's website http://www.enfield.gov.uk/info/1000000845/the_care_act_2014 and a national public awareness campaign and toolkit is due, supplied by Public Health England.

- **Operational Change Management** – the new duties contained in the Act will result in a change to how adult social care is delivered with a particular focus on key principles of wellbeing, preventing and reducing need and outcomes for local people. Although some of this is already in place as a result of the Council's approach to Personalisation, it will mean significant changes to business practices, for example a new eligibility framework, new Carer duties and a focus on prevention and what matters to the individual

- **IT and Business Intelligence** – the new duties require a number of changes to systems including the HHASC e-Marketplace and customer contact and assessment. This is in progress and delivery planned for February 2015

- **Safeguarding Adults** – a gap analysis has been completed and work-in progress including for Making Safeguarding Personal.

4. BETTER CARE FUND

4.1 Enfield HWB Better Care Plan submission was submitted on September 19th 2014 with the agreement of the Chair of the Health and Wellbeing Board, the Chair of the Clinical Commissioning Group (CCG) and the Leader of the Council. The plan was "Approved with Support". This means that the plan is sufficiently well developed and robust to NOT require a re-submission, but further evidence was required by NHS England (as the regulatory organisation) before the Plan could be fully approved.

4.2 Around 20 outstanding actions were agreed between NHSE London and the Enfield BCF team. Most queries were resolved through the discussion with a small number of queries requiring further evidence or correction in the supporting documentation.

The outstanding actions can be resolved by providing additional information and minor amendments to text (e.g. lists of engagement events, corrections in the BCF Plan narrative to ensure consistency across the documentation or development of user satisfaction methodologies). The exception to this is the agreement of the BCF governance structure which is the subject of a separate report to this HWB meeting.

4.3 Once the HWB has determined the governance structure for BCF, in accordance with the requirements of the BCF national guidance, LBE and ECCG will be required to publish the BCF plan on their respective websites in order to achieve full approval.

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 From a patient perspective, delivery of the following objectives should allow older people to be able to say: "*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me*" (National Voices).

To support this, the Integrated Care model for older people should provide and result in:

- Better and more pro-active identification of patients who could benefit from a community-based approach to care and support across all relevant agencies;

- Better coordinated and joined up assessment, care planning, treatment & case management of older people, appropriately tailored to their needs & preferences, in a preventative, planned & enabling way to:

  ➢ Ensures the patient and carers are at the heart of what's important to them is a critical part of care planning & delivery;

  ➢ Ensure all elements of the care & support system act as single system to provide care to individuals, with care delivered in the most appropriate setting for patients & their needs through cross-sector partners working together;

- Improvements against a range of outcomes for older people and their carers including improved or maintained health, independence, quality of life and greater choice and control over their options;

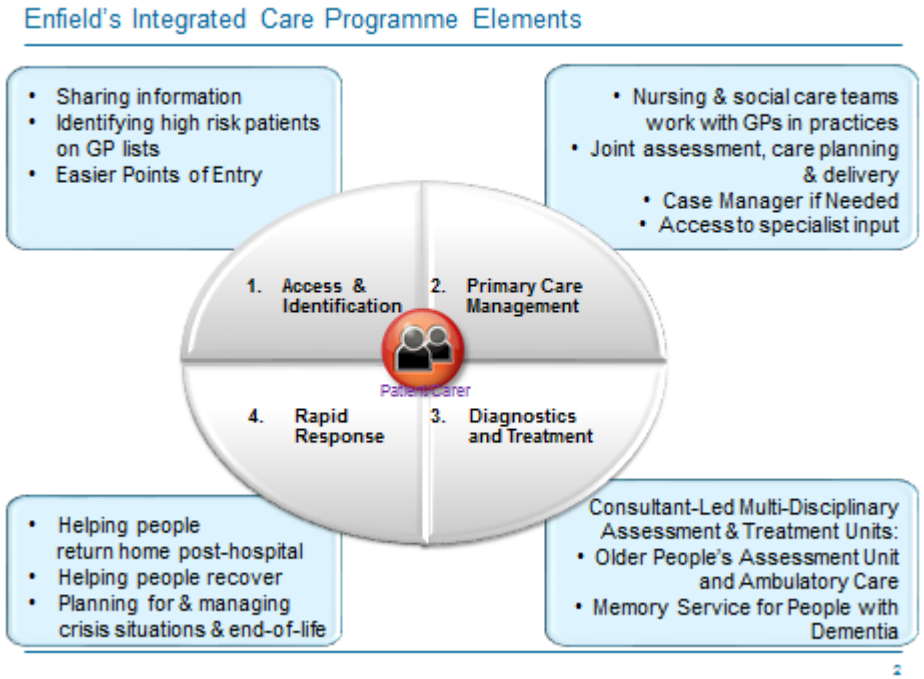
- Reduced crisis-driven episodes of care and support, including reduced hospitalisation and less intensive social or health care solutions, and in so

doing manage activity and costs sustainably across the health & social care system;

- Appropriate infrastructure, e.g. in terms of information and IT and workforce development, to realise these objectives.

The figure below shows the structure of, and functions within, the integrated care pathway for older people in 2014/15 and 2015/16.

The group of patients who are the main beneficiaries of the model in 2014/15 are the 4,000 older people in the "top 2%" of patients most at risk of emergency hospital admissions based on their history of hospitalisation as part of NHS England's GP Enhanced Service for Unplanned Emergency Admissions, the management of whom practices are paid.



The main beneficiaries of the model in 2015/16 will be the 50% of older residents (20,800 aged 65+) who can be described as "frail" and "pre-frail", and in particular the 7,200 older people who are "frail" or "high-risk pre-frail".

The Better Care Fund Plan will be an important delivery mechanism to expand the pathway in 2015/16.

5.2 Identification and Primary Care Management

Working in partnership between NHS Enfield CCG, London Borough of Enfield and their community care providers, the integrated care model has developed a risk stratification tool to identify those most at risk and Integrated Locality Teams, teams initially composed of social workers, community matrons and therapists, a multi-disciplinary, multi-agency approach to supporting GPs in

their role as Lead Accountable Professional in their practices in each of Enfield's 4 CCG localities (see table).

Future plans include working with the voluntary sector to develop pan-sector support for healthy ageing for older people with frailty in partnership with the CCG and LBE.

Update	Achievements	Next Steps
E-Risk Stratification Tool implemented allowing GPs to view primary & secondary care health and social data and identify top 2% of patients at risk	Only one of few Boroughs to have enabled GP access to health and social data GPs identified 4,000 older patients in top 2% of cases	E-Risk Stratification algorithm being refined to improve identification process and prepare for 2015/16 changes
Initial **GP Care Plans** were developed for the "top 2%" of cases	3,700+ plans developed during Jul-Sep-14	CCG to launch outcome-based scheme to incentivise GPs to work with Locality Teams
Integrated Locality Teams: Additional resources in community health & social care to support case management	182 cases in "top 2%" were subject to multi-disciplinary approach in 2014/15 – target is 600 cases for year	**Locality Teams**: 2015/16 model agreed with partners & delivery expectations set out in Community Health contract
Falls Service currently supporting patients at falls risk, and facilitating professionals' access to support	Positive feedback from patients about service, but more needs to be done to improve GP access	**Falls Service** being evaluated with view to re-develop it into integrated care pathway

The Care Homes Assessment Team (CHAT) is a nurse-led team with geriatrician input to both help manage the individual cases of older patients in homes with the highest level of emergency hospital admissions, help develop lasting nursing staff skills in these care homes and engage with GPs with patients living in these homes; it is estimated 25% of the "top 2%" on GP lists live in care homes, with all residents in these homes are older people with frailty.

There was 8% reduction in the number of emergency admissions from those homes with which CHAT worked between 2012/13 and 2013/14. Given their success, the CCG recently agreed additional investment in the team and the service increased its coverage from 17 to 25 homes in 2014/15.

5.3 Diagnostics & Treatment

The *Older People's Assessment Units* (OPAUs) – one at Chase Farm, one at North Middlesex University Hospital – are consultant-led, multi-disciplinary non-inpatient units to facilitate GPs same or next day access to assessment, diagnostics, treatment and intervention to support primary care case management. GPs referred 1,500 older people with frailty to Enfield's OPAU between Aug-13–Jul-14 (160–175 patients per month in 2014/15) and an analysis suggesting the vast majority (at least 85%) were appropriate.
Feedback from GPs and patients has been overwhelmingly positive about the service and its outcomes, and there is some evidence of reduced hospitalisation as a result of intervention, with an overall reduction in emergency hospital admission rates amongst those referred. The NMUH OPAU had fewer referrals than intended and partners are working with the

Trust to re-develop its ambulatory care "offer" for older people as an alternative mechanism to deliver the same clinical function as the OPAU (together with other unscheduled care functions such as admission avoidance in A&E) in a more effective and efficient way for patients.

5.4 Rapid Response

This function includes both crisis management arrangements to help people avoid hospital admission often as a result of a crisis and to facilitate hospital discharge. Enfield has successfully operated well-coordinated Intermediate Care & Enablement functions for several years, whilst improved joint hospital discharge processes helped reduce the number of delayed transfers of care. The next phase of development is to align these functions with the Integrated Locality Teams to promote care closer to home for patients.

NHS Enfield and LBE also invested in assistive technology to support patients and provide reassurance, including the re-launch of LBE's Community Alarm & Tele-care Service into Safe & Connected to provide reassurance to older and/or vulnerable people that help is available "at the touch of a button" through the triggering of alarms/sensors, and Tele-Health.

Tele-Health is the GP-prescribed use of electronic equipment to remotely and daily monitor patients with specific long-term conditions, such as cardiology or respiratory conditions, vital signs & symptoms (e.g. blood pressure). If outside their normal range, an alert is sent remotely to health professionals to check the readings and patients. Its aim is to improve patient condition management and reduce adverse health episodes. Enfield is currently evaluating its Tele-Health pilot of 41 patients with several GPs. The emerging findings are that access to the equipment and system of support is popular with patients and GPs and it has made a difference to hospitalisation rates for many patients.

6. PUBLIC HEALTH

6.1 BEH MHT Community Services Contract

The CCG has postponed the procurement of Community Services due to data and performance validation issues, which has placed the Council with the options of:

(a) Do nothing and extend contract with current provider in line with the CCG

(b) Put Council community services out to tender, being:

(i) Reproductive and Sexual Health (level 1 – 3) services, which covers all methods of reversible contraception, cervical cytology, medical gynecology psychosexual medicine, vulval dermatology, counselling and referral for male and female sterilisation, basic level infertility, GUM and HIV diagnosis and prevention, Outreach services for

under 19s in schools and centres - young peoples' integrated sexual health services, advice on and management of unplanned pregnancy; and

(ii) School Nursing, which covers the National Immunisation Programme, Childhood Obesity and Teenage Pregnancy

(c) Review the management process of both services with the possibility of entering into an agreement under Section 75 between the Council, CCG and provider; with the provider providing the clinical governance responsibility and the Council managing the contract

The Council has a responsibility to ensure transparent and competitive marketing and tendering, therefore it is not in the Council's interest to opt for option (a) as the current contractor has been providing the service since 2010.

7. CCG Commissioning Intentions

7.1 Co-Commissioning *[Contribution from Head of Primary Care, NHS England (London Region, North, Central & East)]*

New Guidance has just been issued and is available at:
http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

Next steps towards primary care co-commissioning gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning models CCGs could take forward:

1. Greater involvement in commissioning decisions
2. Joint commissioning arrangements
3. Delegated commissioning arrangements

The scope of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints

management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

Under joint and delegated arrangements, CCGs will have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest.

In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

With regards to governance arrangements, draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs, have been developed. A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary resources as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

The approvals process for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to "special measures", NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma and request a constitution amendment. The approvals process will be led by regional

moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements.

It will be made as simple as possible for CCGs to change their co-commissioning model, should they so wish.

8. SERVICE AREA COMMISSIONING ACTIVITY

8.1 Older People

8.1.1 Enfield Warm Households Programme

Keep warm, keep safe is a big part of LBE preventive programme for 2014/15. It is to enable vulnerable people to keep warm and safe in winter. The Council has agreed an allocation of funding to support vulnerable people in Enfield in this year's programme.

Voluntary & Community Sectors have been invited to submit bids to support and provide a service for the winter months of December 2014 – March 2015 to support identified vulnerable children and adults in Enfield.

8.1.2 Dementia

The end to end review of the Dementia Pathway has been completed and the final report is near completion. The findings of the review will be incorporated into commissioning intentions and delivered via the Better Care Fund.

Waiting times for the Memory Service had increased to more than 13 weeks; NHS Enfield CCG invested additional funding to manage this and reduce waiting times; the current waiting time has been reduced to 8 weeks. It is expected that this will reduce further and be maintained at 4-6 weeks.

8.2 Mental Health

8.2.1 Joint Mental Health Strategy – The strategy was recently approved by the Council's Cabinet. Implementation of the strategy continues to be monitored by the Joint Strategic Implementation Group having previously been agreed by the CCG Board.

8.2.2 Enfield Joint Autism Framework

The Enfield Joint Autism framework has been finalised. It will be published on the Council and CCG web-sites. The programme aims to:

a. Improve the co-ordination of services for people with autism
b. Improve the provision of information and advice to adults with autism
c. Improve the signposting of adults with autism to appropriate information, advice and services

d. Map and collate information about the information, advice and services available in Enfield and have this included in the Council online directory and CCG web-site as appropriate.
e. Develop care pathways and gain an understanding of met and unmet need

The funding available for implementation of the Autism Framework will be allocated to the independent sector through a small grants procurement process. This small grant procurement process started at the beginning of November with market engagement activity to ascertain if the local independent sector market in Enfield has an interest and the necessary skills and expertise to implement the Autism Framework and reenergise the Autism Steering Group to oversee our improvement plans for people with autism and their parent / carers.

8.3 Learning Disabilities

8.3.1 Learning Disabilities Self-Assessment Framework (SAF)

Public Health England is working in partnership with the Improving Health and Lives (IHaL) website to facilitate the development and delivery of the national SAF for 2013/14. The SAF for this year focusses on the following themes:-

- joint working
- integration
- accessing universal services
- improving access to primary care services
- addressing health inequalities
- empowering people with learning disabilities by involving them and their carers in decision making processes.

The SAF was launched at the end of September 2014 and the deadline for submission will be March 2015.

Enfield has already started its information and evidence gathering to support this year's SAF submission. The Integrated Learning Disabilities Service will work closely with commissioners and the Learning Disabilities Partnership Board to develop and submit the SAF for 2013/14.

8.3.2 Transforming Care for People with learning disabilities Programme (Winterbourne View)

NHS Enfield Clinical Commissioning Group (CCG) and the Council have developed a joint action plan in response to the Winterbourne View concordat. Key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism in low-high in-patient facilities to ensure that people are appropriately placed and where appropriate, to have a discharge plan in place with a view to transitioning back to the community.

Where people are considered as inappropriately placed there is emphasis on considering community based services that are closer to home. Enfield completed reviews by the June 2013 deadline and are currently on track in terms of meeting the conditions of the concordat action plan. Patient choice and parent / carer involvement continues to be the focal point of implementation of the concordat action plan. Since the last update to the HWBB we have:-

- Reduced the number of people with learning disabilities in our assessment & treatment services
- Reduced the number of people with learning disabilities in long stay hospitals
- Diverted funding from assessment & treatment services into community intervention models of healthcare through section 75 partnership arrangements
- Provided learning disabilities specific mental health awareness training to service providers of people with complex needs and behaviour that can prove challenging at times
- Our clinicians have provided training to other areas on minimising the use of medication by offering holistic interventions for people with complex needs
- Applied for DH Capital funding to support local delivery of the Winterbourne View programme by developing a range of housing options for people with learning disabilities with complex needs

8.3.3 Community Intervention Service for people with complex needs

Our Community Intervention Service is fully operational and is part of the Multi-Disciplinary Team Integrated Learning Disabilities Service under Section 75 partnership arrangements. This service was developed in response to the Concordat Action Plan and has directly attributed to reducing the numbers of admissions to our in-borough assessment & treatment service. Lengths of stays have also been shortened due to the community intervention service offering intense resettlement support back to the community.

The CCG agreed reoccurring funding for the Community Intervention Service at the beginning of November. NHS England recognised the Community Intervention Service as a Good Practice healthcare model by requesting case studies for publication in national reports.

In terms of planning services, we are currently finalising our Joint Learning Disabilities Need Assessment that will form part of the Borough's Joint Strategic Needs Assessment and be used to develop our commissioning intentions for the next 3 years.

Enfield in partnership with a Registered Social Landlord, was successful in accessing the Mayors Care and Support funding last year. We are developing a range of supported living services that will be specifically designed for people with learning disabilities with Profound and multiple, Complex needs and an extra care service for older people with learning disabilities who also have dementia. The development will be opened within the next 12 months.

From the Mayors Care and Support funding, we will also be developing 4 homes for people with learning disabilities and / or physical disabilities which will be available to buy through shared ownership options.

The CCG in partnership with Enfield Council and Mysupport broker, have expressed an interest in taking part in NHS England's Integrated Personalised Commissioning Programme that will provide a network of support opportunities and best practice guidance to implement and embed the following objectives in terms of implementing integrated health and care models locally:-

- People and their Carers have better quality of life and can achieve the outcomes that are important to them and their families
- Preventing crises in people's lives that lead to unplanned hospital and institutional care.
- Better integration and quality of care,
- The programme builds on personal health budgets, Long-Term Conditions Year of Care programme, the Integration Pioneers and work with Monitor and HSCIC

8.4 Carers

8.4.1 Enfield Carers Centre

The Centre now has 3,156 carers on the Carers Register. In addition, 787 carers hold a Carers Emergency Card. In the July-September 2014 quarter, the Centre registered 375 new carers.

The Carers Centre respite programme has allowed 129 carers to receive a break between July-September and the new befriending programme has resulted in a further 6 carers receiving a regular weekly planned break.

Enfield Carers Centre has now recruited a full time Benefits Advisor who took up their post in April 2014. In the July-September quarter, 83 carers received benefits advice.

The Hospital Liaison Worker continues to work on the wards at North Middlesex, Chase Farm and Barnet Hospital. Leaflets and posters are distributed and supplies kept topped up throughout all hospitals. Barnet Hospital has also a permanent pop up banner advertising Enfield Carers

Centre near the lifts next to the outpatients department. In the quarter of July-September 2014 the Hospital Worker identified 102 new carers.

The Advocacy Worker has been taking up cases and has continued to promote the services within the VCS and with practitioners. In the July-September 2014 quarter they provided support to 66 carers.

The Young Carers Worker pilot project has now reached conclusion and in the final quarter the Young Carers Project identified 65 young carers. Work in primary schools will now be continued by DAZU Young Carers Project (the contracted service).

Enfield Carers Centre has now established their transition project for young carers as they approach 18 and enter adult services. This is known as the Young Adult Carers Project. In the first quarter of operation the Young Adult Carer Project has identified 31 young adult carers.

The Centre's training programme has seen 135 carers attend a training sessions over this quarter. A further 38 carers have received one to one counselling during this period.

8.4.2 Carers Direct Payment Scheme

We now have 139 carers receiving a Direct Payment through Enfield Carers Centre with others awaiting approval.

8.4.3 Carers Rights Day

Plans are underway for Carers Rights Day 2014 which will be hosted at the Civic Centre on Friday 28th November from 10am - 2pm. The focus for the day will be The Care Act and Children and Families Act which offers new rights to carers.

The agenda is as follows:

The Care Act – New Rights for Carers
Keezia Obi, Head of Service - Care & Support, London Borough of Enfield

Expert Panel – Question and Answer Session

- Ray James, Director of Health, Housing and Adult Social Care
- Janet Leach, Head of the Joint Service for Disabled Children
- Aimee Fairbairns, Director of Quality and Governance, Enfield CCG
- Scott Kerr, Service Manager Enfield Acute Care Services, BEH Mental Health Trust
- Pamela Burke, Chief Executive Officer, Enfield Carers Centre

Lunch

Choice of workshops:
- Carers and benefits - What you are entitled to
- Advocacy – Getting Your Voice Heard

Information stalls from:

London Borough of Enfield, Enfield Carers Centre, DAZU, Naree Shakti, Mencap, Crossroads Lea Valley, HealthWatch Enfield

8.4.4 The Employee Carers' Support Scheme

An event for the week after Carers Rights Day is planned to promote the Carers Action Group.

Development of pages for the staff 'Enfield Eye' intranet and content is currently being developed. Development of a staff e-learning package in carer awareness has been agreed as a priority.

8.4.5 Primary Care*

The GP project has now seen 217 new carers registered through either the GP or the self-referral method from the surgery information. 14 surgeries have a permanent carers' noticeboard. 14 surgeries are now hosting regular carers information stands and 25 practices now have carers' post boxes on reception. All surgeries have now been visited and all of these have been given an information pack and provided with referral forms with their own surgery code alongside the self – referral cards which also hold a unique surgery code. 46 practices are now actively engaging in the project. All pharmacies have been written to in the reporting period and three are now actively engaging in the project. A bi-monthly E-bulletin is sent to all the practices that have been visited with a project update and a request for further engagement. (*All statistics are to the end of Sept 2014)

The GP Liaison Manager met with Dr Anne Mulroy from the Royal College of General Practitioners (RCGP) in August to discuss the project's progress and to talk about the Carers Champions in Practice Scheme. Dr Mulroy, who is the GP Carers Champion for London, was very impressed with the GP Liaison Project in Enfield and was particularly keen to adopt in other boroughs our policy of having carers' self- referral boxes in practices. Further partnership work is to be pursued between the RCGP and Enfield Carers Centre.

8.5 Children's Services

8.5.1 Family Nurse Partnership (FNP)

Enfield Family Nurse Partnership continues to progress well and recently held its first Annual Review. Young mums and their babies spoke about their

positive experiences of the service. There are encouraging results on breastfeeding and immunisations rates. In addition there have been reductions in smoking, and alcohol and substance misuse rates in women participating in FNP. There has been a high need for housing and benefits support and this has taken up more time than expected to resolve and this is higher than the national programme average. The rates of engagement/re-engagement with employment and education are promising. Overall the Enfield FNP programme is meeting all of its targets.

The FNP Team received 94 eligible referrals in the first ten months. One hundred referrals were expected. By April, 2015, the FNP will be full and unable to accept further referrals.

55 young women enrolled for the programme. Four clients are subject to Child Protection Plans and one infant is currently subject to a Child in Need Plan. Some young people were not eligible for the FNP because they lived out of area, were too old or too advanced in their pregnancy. The latter group were referred onto the HV Teams for additional support. For the first time teenagers who have moved from other FNP areas have been not been accepted by Enfield FNP because of the team's capacity issues. It is being explored whether teenagers can remain with their initial FNP nurse, so that they may continue to receive support.

8.5.2 Health Visitors

The campaign to recruit additional Health Visitors continues to be successful and the service is currently introducing a second universal check at 8-10 weeks. This is a critical point for identifying post-natal depression and other issues and will strengthen the overall early years offer to children and families in Enfield. As more Health Visitors are recruited the programme will be further extended. Responsibility for commissioning Health Visiting is due to transfer from NHS England to Public Health at the Council in October 2015, and work to ensure an effective transition is underway.

8.5.3 Maternity

Enfield CCG continues to monitor important quality issues in monthly meetings and through the North Central London Maternity Board. Early booking with a midwife (by 12 weeks and 6 days of being pregnant) achievement has improved at North Middlesex University Hospital but is still below national targets. The caesarean section rate at Barnet General Hospital has reduced although it remains one of the highest within NCL. There has been steady progress in improving mental health services for pregnant women and up until their baby's second birthday (known as the perinatal period). The Tavistock & Portman Clinic is providing perinatal mental health training on behalf of Enfield and other CCGs within the North East London

8.5.4. SEND/Children and Families Act Implementation

The Children & Families Act introduces the biggest changes to the Special Educational Needs and Disability (SEND) system for 30 years for children/young people and their families, Local Authorities, Health and Schools. The new system will be implemented from September 2014 when the reforms will be statutory.

The main changes to affect families are:

- Replacing Statements of SEN with the new statutory Education, Health & Care Plan from September 2014;
- A new SEN Code of Practice;
- Personal Budgets
- The Local Offer
- Mediation for Disputes
- Expressing a Preference (including Free Schools, Academies and FE)

Eight work streams have been set up to look at how different aspects of the reforms will be implemented in Enfield.

Enfield, in partnership with Bexley and Bromley has been awarded Champion status. The role of Champions is to share and disseminate good practice. In addition to the prestige of being a Champion there is a small amount of additional funding. The Local Offer was published as required at the beginning of September. Good progress is being made with other work streams as detailed in the recent report to the Health and Wellbeing Board.

8.5.4 Paediatric Integrated Care

A paediatric integrated care work stream was initially established to support implementation of the Barnet, Enfield and Haringey Clinical Strategy, and is now supporting the development of the Child Health and Wellbeing Networks included in the Better Care Fund submission. The new networks will enable care to be designed around the needs of children and families taking account of both their physical, social, and emotional, circumstances and providing access to expertise from across the professional spectrum, but most importantly from children and families themselves. A multiagency workshop is being planned for December.

8.5.5 Joint Enfield Council and CCG Children and Adolescent Mental Health Service (CAMHS) Strategy

Enfield Council and CCG have commissioned Keren Corbett Consulting to write a CAMHS Strategy. The joint strategy will set out the way in which Enfield will commission a comprehensive and integrated Emotional Wellbeing and Child and Adolescent Mental Health Service and improve outcomes for children and young people in Enfield. The intention is to take a whole systems approach, with the aim of ensuring that the mental health and emotional well-being of children and young people become everyone's concern.

8.6 Drug and Alcohol Action Team (DAAT)

8.6.1 Successful Completions (Drugs)

The DAAT's performance against *Successful Treatment (Drug Free) Completions* has shown a slight decline for the 12 month rolling data for the period September 2013 to August 2014 evidencing that Enfield has achieved 23.8%, being 4.1% above the London and 7.4% above the National averages. The DAAT has been working proactively with the local three main providers to ensure that the performance for December and going forward demonstrates the required upward trend to achieve a satisfactory position.

8.6.2 Numbers in Effective Treatment (Drugs)

Performance for the indicator *Numbers Retained In Effective Treatment* (*defined as those drug users who are retained in treatment for 12 weeks or more or who are discharged free of the presenting drug problem within 12 weeks from the date of treatment start*) is below the target of 1068 as 883 were in Effective Treatment during the latest monthly date release for May 2014. The contracted providers have very recently assumed assessment responsibility to address the improvements needed to reduce attrition which will increase the Numbers in Effective Treatment going forward. The DAAT has also made significant changes to the partnership arrangements in the operational teams to improve opportunities further.

8.6.3 Numbers in Treatment and Successful Completions (Alcohol)

The performance for the number of alcohol users in treatment remains consistent. Enfield's successful treatment rate is in keeping with the London and National averages at 39.7% for the 12 month rolling period September 2013 to August 2014.

8.6.4 Young People's Substance Misuse Performance

The performance for young people in treatment remains strong at 173 for the latest 12 month rolling period and it is pleasing to note that the Planned Exists has increased from 76% in 13/14 to 91% this year; a rise of 15%.

9. HEALTHWATCH ENFIELD

9.1 From April 2014

Over the past year we focused on 4 key areas of work which are outlined below. In addition we continued to attend a range of partnership boards to ensure the voice of patients and service users was heard, with140 meetings attended since April.

We have responded to 18 formal consultations from statutory agencies. In addition we promoted 54 consultations, encouraging patients and service

users and their organisations to respond directly to ensure their voice was heard.

Signposting: We have ensured that our website has a full range of information about local health and social care services as well as details about complaints processes. This forms the basis of our signposting work and we get between 350-400 new website visitors a month. In addition we have dealt with 60 individual telephone/letter enquiries since April.

We have now recruited a diverse team of **volunteers** who have been fully trained and are assisting with our Enter and View visits (see below) and our community engagement work.

Community Engagement: Since April we have carried out 56 engagement activities across the borough. These comprised focus groups, pop-up stalls and meetings. A report on our outreach work with BAME residents and the issues identified was presented to our Board in September.

Enter and View: Using our statutory powers to Enter and View care homes we carried out two visits in August. Concerns arising from one of the homes have been communicated to relevant Enfield, CQC and CCG officers. Both reports are up on our website and contain recommendations. We are carrying out a joint visit with Barnet HealthWatch to a mental health ward at Chase Farm hospital in December and have a schedule of further visits planned. Our 4 key areas have been:

- Mental Health services – working jointly with Haringey and Barnet HWs, carrying out Enter and View visits and meeting service users and patients.
- GP access – GP Audit report published, feedback from Annual Conference on GP services published and a further audit of premises planned.
- Access to services for people with sensory impairment - we will be producing a joint report with Enfield Disability Action on Access to services for Deaf residents and are part of the group working on the Enfield Vision Strategy.
- Monitoring the impact of the BEH Clinical Strategy, specifically changes to A&E provision and more recently the impact of the Royal Free acquisition of Chase Farm/Barnet hospitals.

All of our work has a positive impact on patients and service users – whether it is provision of information, ensuring the patient/service user voice is heard or securing improvements in service – some of which are highlighted in the ‘You said, We did’ section of our website.

Events: In April we held a well-attended workshop for voluntary organisations focused on complaints processes. This led to us creating a dedicated section of our website devoted to complaints and advocacy. In October we held our

Annual Conference which was so successful we had to turn people away. This focused on the Care Act and on GP services. We launched our GP Audit report at the conference.

10. VOLUNTARY & COMMUNITY SECTOR STRATEGIC COMMISSIONING FRAMEWORK (VCSSCF)

10.1 Following the recent publication of the final Care Act Guidance and Regulations, Commissioners are reviewing strategic objectives and service priorities. The VCS will play a key role by complementing provision from the private and statutory sectors and enhance the range of quality services and supports that are available to meet community care needs.

The Better Care Fund is an opportunity to accelerate our work in this area and, in particular, our aim to develop voluntary and community services that supports existing work to delay and, where possible, to prevent hospital admissions and requirements for social care services. Incorporating these organisations more deeply into our ongoing work in this area will increase the capacity, capability and flexibility with which we can achieve this.
Key service areas for the VCS include preventative services and supports; information, advice and guidance and advocacy.

10.2 'Keep warm, Keep safe' is a big part of maintaining good health in winter and there are many ways that the VCS sector can assist vulnerable and older people to keep warm and keep safe. Colleagues within the Public Health function have recently announced the 'Enfield Public Health Winter Health Fund' and in order to maximise the potential support to vulnerable people in HHASC Commissioners are now inviting applications from various Enfield VCS to complement and enhance this year's overall programme targeted, at helping vulnerable and older people keep warm and connected in winter. The Council has agreed a £120k allocation with funding contributions from Health, Housing & Adult Social Care.

11. SAFEGUARDING

11.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board will be notified of Quarter two performance data at the September Board meeting.

11.1.1 Key headline data for Q2 is:

(i) The number of alerts raised to adult social care during Q1/ & Q2 is consistent with the number recorded during the same period in 2013/14 (501 in Q2 13/14 to 506 in Q2 14/15). This is a change to previous years which reported a 53% increase during 2011/12 to 2013/14.

(ii) The largest referrals increase across all teams is Older People 17%, (308 to 371).

The MH team reported a 75% decrease in the number of referrals reported for 18-64's (82 to 20).

(iii) 42% referrals are in relation to alleged abuse in the Adult at Risk's own home and 27% are in a residential/nursing home. 36% and 31% respectively was reported during the same period in 2013/14.

- Where the place of the alleged abuse is reported as 'MH inpatient setting', the number of referrals has decreased by 60% (33 to 13) since 2013/14.

(iv) Most alerts relate to Multiple Abuse (36%) with Neglect at (29%). Neglect is higher when compared to 2013/14 which has seen a 31% increase (110 to 145).

11.1.2. Further to the Supreme Court Ruling on 19th March 2014 on Deprivation of Liberty safeguards there has been an increase in applications. The ruling noted the acid test for a DoLS was:

(i) Under continuous supervision and control
(ii) Not able to leave
Objection is now irrelevant.

In 2013 – 2014 there were 66 applications. From April 2014 there have been 412 applications FYTD. A strategic plan is in place to manage this increase. Enfield has enrolled in the LGA / ADASS Making Safeguarding Personal programme at Gold level. This is an approach intended to support councils and their partners to develop outcomes-focused, person-centred safeguarding practice.

11.1.3. The purpose of Making Safeguarding Personal is to bring about more person-centred responses, which can be beneficial to people in safeguarding circumstances. It is about exploring with them (and/or their representatives, advocates or Best Interest Assessors) the options that they have and what they want to do about their situation. This includes asking them what they want by way of outcomes at the beginning and throughout safeguarding interventions. It is about negotiating around those outcomes and then, at the end, to ask them about the extent to which those outcomes have been achieved.

Bournemouth University has been commissioned to undertake an evaluation of the MSP Programme.

11.1.4 There are five sub-groups which support the work of the Safeguarding Adults Board:

(i) Service User, Carer and Patient Group;
(ii) Performance, Quality and Safety Group;
(iii) Learning and Development Group;
(iv) Policy, Procedure and Practice Group; and
(v) A Joint Safeguarding Adults and Children's Sub Group.

All sub-groups report to the Board bi-annually on the work it has achieved, which is included in the Board's Annual Report.

11.1.5. A Joint Safeguarding Adult's and Children's Board sub-group has been recently implemented. This represents the interface between Adults and Children's Safeguarding and will ensure that issues common to both the Safeguarding Boards are promoted and monitored.

11.1.6. The Enfield Safeguarding Adults Board is in the process of producing a draft Enfield Safeguarding Adults Board Strategy 2015 – 2018. Details of consultation will be advised in the near future.

11.2 Community Help Point Scheme on Tap-IT

11.2.1. The mobile safety app that helps residents keep connected continues to be downloaded from the iTunes store and Google Play. The app also provides information on the nearest police station and 'safe sites' that have been approved through the local council CHPS scheme.

11.2.2. The CHPS scheme has provided a list of locations for the Community Help Points on the Children's Safeguarding Board website: http://www.enfield.gov.uk/enfieldlscb/info/2/children_and_young_people/186/community_help_point_scheme

11.3 Safeguarding Information Panel (SIP)

The Safeguarding Information Panel is made up of Enfield Council Safeguarding Adults, Contracting, Environmental Health, Enfield Clinical Commissioning Group (CCG) Safeguarding, Care Quality Commissioning (CQC) and the Police.

The SIP continues to meet every 6 weeks; safeguarding information about care homes and care providers is shared and appropriate interventions or necessary support is identified and implemented. The information shared at this meeting includes:

- number of deaths in care homes,
- whether a registered manager is in post,
- number and nature of safeguarding adult alerts for the provider,
- CQC compliance and enforcement actions, and
- feedback from safeguarding provider concerns and contract monitoring activities.

The panel is starting to receive referrals from the care teams and from Enfield Community Services nurses and teams (including the Care Homes Assessment Team). The most recent SIP meeting considered safeguarding issues at a number of Enfield hospital trust wards. The next SIP will consider alerts by the hospital trusts and the most appropriate next steps.

11.4 Quality Checker Programme

The Quality Checkers are service user and carer volunteers who visit services and give us feedback. The focus of the visits remains care homes and people receiving services in their own homes. Since 1st April 2014, over 100 visits have been completed. These include visits as part of the Dignity in care panel reviews, care home visits, and visits to peoples' homes. As part of the Dignity in care panel reviews, Quality Checkers have received additional training around support planning and dementia awareness.

The programme has recently completed a two week intensive visit programme to 4 of Enfield's Libraries. In general, the feedback from these visits has been very positive.

11.5 Quality Improvement Board (QIB)

At the August QIB, updates were received from the four key project areas: the Quality Checking visits (see 11.4 above), the Improving Resident's Lives group (care home managers' group), Care Home Carers Network, and Dignity in Care panel reviews:

11.5.1 Improving Residents' Lives Group (care home managers sub-group)

The Improving Residents' Lives sub-group (which is the legacy group from MyHomeLife) action plan has been considered by the QIB. It has been approved for action. This is now being implemented through meetings which follow the MyHomeLife model, includes colleagues from Enfield Council and Enfield Clinical Commissioning Group, and is chaired by Pauline Kettless, the Enfield Council Head of Brokerage, Commissioning, Procurement and Contracting. The group has met and care home manager leads have been identified for improvement areas. A key area of improvement, from the action plan, is the process of hospital discharges into care homes. To facilitate improvements, care home managers will be attending the Discharge steering group meeting in the coming months.

11.5.2 Care Home Carers Network

The QIB was also informed that Care Home Carers' Network, an improvement project which had been suggested by Quality Checkers and is being led by Rosie Lowman, Enfield's Carer Commissioner. A project management group led by Rosie Lowman, with the Over 50s Forum, the Alzheimer's Society, Age UK, the Carers Centre and some carers has been set-up to develop the project. A pilot project is being developed with a care home provider (who has multiple sites in Enfield) to create effective residents and relatives meetings.

11.5.3 Dignity in Care Panel

The Dignity in Care panel reviews services to determine if they are meeting the Dignity in care challenge. The Dignity in Care panel is piloting their provisional methodology at services run by Enfield's Independence and Well-

being service. The Dignity in Care panel has completed visits for reviews for all of our day services, except for New Options, which is being visited early 2015. They have fed back directly to managers and have asked for comments about the process. Action plans have been developed, and a sign-off visit is made in three months to determine if they are meeting the Dignity in Care challenge. Three sign-off visits have been completed. Panel members have been impressed with the quality of service across the Independence and Well-being service and the response of staff to their visits.

11.6 Multi-Agency Safeguarding Hub (MASH)

11.6.1 As part of its ongoing work to transform services in Enfield Adult Social care is seeking to create a multi-agency safeguarding hub (MASH) for vulnerable adults. With a significant increase in the number of safeguarding referrals year on year and a need to respond quickly, often across multiple areas of responsibility, developing a MASH which will see the co-location of staff from adults' services, police and health makes sense. This will fit with the MASH currently in place for children. It has been agreed that, as an interim solution, a joint MASH will be located within space currently in use by the children' s SPOE with additional space to be provided as part of the Enfield 2017 transformation programme. This will be effective from 1st April 2015. Once renovation works are completed on the 9th floor of the civic centre, the service will be relocated there. It is anticipated that the move to the 9th floor civic centre will take place in September 2015

Currently all safeguarding referrals come through the Access service in Adult Social Care. This is not a multi-disciplinary team. Access acts as a triage service and all referrals that require further investigation are sent out to the responsible care management teams.

The MASH will deal with all new safeguarding concerns including merlins from the police, where someone is concerned about the safety or wellbeing of an adult, or think they might be at risk of harm.

11.6.2 How will the MASH operate? Within the MASH, information from different agencies will be collated and used to decide what action to take. As a result, the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that vulnerable adults at risk are kept safe. Where there is a need for further investigation, these cases will be transferred to the appropriate service. Where it is decided that no further investigation is required appropriate information and advice will be given. Given the potential for a multitude of different agencies to be involved in the referrals which come through, it would be appropriate for some agencies to be virtual members of the MASH. This means that, although a physical presence may not be necessary, a named resource will be contactable and available to provide information and advice as necessary.

The MASH will have a dedicated phone number for all queries. There will also be an on-line form available for people to refer directly to the MASH.

Developments are already underway to develop on-line forms that will feed directly into the client information system (CareFirst). These will all go to a dedicated MASH clipboard.

The group has previously received an update on the background to and need for an Adult Multi-Agency Safeguarding Hub. This update relates specifically to actions either planned or delivered to date.

The MASH steering group is chaired by the AD for Adult Social Care services and includes stakeholders from across the Council and other statutory bodies. The steering group is supported by two sub-groups, the MASH practice group and the MASH IT/infrastructure group. Progress made to date includes:

- A new process for how the Adult MASH will work and how it will fit with the Children's MASH already in place
- Agreement reached on what resource will be allocated from which services to sit within the Adult MASH and what resource will be shared across both Children's and Adults MASHs
- Due to the Enfield 2017 Transformation programme the Interim accommodation agreed for the new combined MASH on the the 5th and 6th floor civic cellular areas is not yet confirmed. This interim solution will be used until September 15
- Long term accommodation solution agreed as the 9th floor civic centre. Planned available move in date is currently September 15 once renovation works have been completed.
- Site visit completed and funding agreed for IT/re-cabling provider for the Police.
- IT System specifications to support both Children's and Adult's MASHs are complete and a system provider has been selected. System delivery for the adult requirements is February 2015. This will give time to test the new system and train staff on its use.
- Capital funding in place to deliver the IT solution
- Contact to be made with other councils who have already implemented joint Adult and Children MASHs across the country to learn good practice
- Information sharing protocol is being reviewed

12. SPECIALIST ACCOMMODATION

12.1 Mayor's Care & Support Specialist Housing Fund

In July 2013, Newlon Housing Trust, supported by Enfield Council and the Health & Wellbeing Board were awarded £840,000 for the demolition and redevelopment of outdated specialist accommodation located off Carterhatch Lane. Planning permission for the development of 14 homes, providing specialist housing with care for older people with learning disabilities (including dementia care needs) has now been granted. People have been decanted from the existing scheme and work has commenced on site. Completion of the new building is scheduled for Autumn 2015.

Work continues to develop wheelchair accessible family homes on Jasper Close. In addition to this we are working across departments and with carers of people with disabilities to develop 2x2 bedroom units of fully adapted wheelchair accessible accommodation for people with long term disabilities to purchase on Parsonage Lane. This innovative pilot scheme is being developed in partnership with an organisation called MySafeHome using a shared ownership model known as HOLD (Home Ownership for People with Long Term Disabilities). The HOLD model enables disabled individuals with a range of different impairments to part buy a fully wheelchair accessible home of their own. Completion of both these developments is scheduled for completion in the Autumn of 2015.

12.2 Department of Health Capital Funding Bid

In October 2014, the Department of Health announced the release of £7million capital funding to support additional or improved housing and accommodation projects for people with learning disabilities, autism and/or challenging behaviour. In November 2014 a bid for £1.45 million was submitted, for the purchase and adaptation of 5 homes from the open market via the Council owned Housing Gateway. A decision on whether this bid has been successful is expected at by the end of November 2014.

13. PRIMARY CARE PREMISES STRATEGY

13.1 The 'Primary Care Premises Strategic Group' was established in February 2014. The purpose of this Group is to provide a forum for key partners to meet and provide long term strategic oversight to current and future primary care premises developments in the borough. The purpose of this Group is solely to consider the development and sustainable supply of primary care premises. Primary care capacity and quality issues will be addressed as part of other initiatives. The Group combines representatives from NHS England, NHS Enfield Clinical Commissioning Group, NHS Property and Enfield Council (various departments). The specific remit of the Group is defined in the Terms of Reference (see Appx 1). The meeting is held on a quarterly basis chaired by the Assistant Director of Strategy and Resources. There have been 4 meetings to date, with the next scheduled on 20th January 2015.

13.1.1 Ordnance Unity Centre Progress Update

The building is now in the final stages of construction (see Appx 2). The contractor is undertaking final decorating, cleaning and testing of the services. A snagging list has been produced and the contractor is working through the defect list. Practical Completion is expected to be awarded in November 2014, following which the user group fit out will commence.

Haverstock Health has been appointed as the new GP Provider following an extensive procurement process. Haverstock Health took over the contract of the existing Ordnance Road Practice on 1st October to manage the transition to the new building. The appointment has been received positively by the

patient group and local community, and approximately 10 new requests to register are being received each day.

Whittington Health has been identified as the new community dentist, to provide a service on a referral basis only and provide additional capacity in North East Enfield.

The Council's Public Health team has developed a publicity campaign, to help raise the profile of Ordnance Unity Centre for Health. This will involve a mail drop to all residents within a five mile radius of the new building to promote registering with a local GP, plus the delivery of free health checks in Coop.

An open day for key stakeholders has been provisionally planned for Thursday 11th December, to provide an opportunity for a guided tour of the building ahead of the formal opening.

14. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

14.1 Learning Difficulties Partnership Board (LDPB)

14.1.1 The learning Disabilities Partnership Board met on the 17th November. This meeting's 'Big Issue' was The Care Act and SEND reforms.

14.1.2 Peppa Aubyn gave a presentation (on behalf of Michael Sprosson, who was unable to attend) on the Care Act. The DoH accessible guide to the Care Act was circulated to members before the meeting. The board thought the content of the Act was good, but expressed concern that without extra funding some elements of the Act might be difficult to achieve. The board also felt the DoH document missed some important information, which was included on the presentation. The board also felt there needed to be further guidance on keeping people safe when they hire their own support, and what constitutes good evidence of outcomes being achieved.

14.1.3 Janet leach then gave a presentation on the SEND reforms. The board were pleased that outcomes were being implemented for children, but reinforced the importance of making sure they are realistic and achievable. The board were also pleased EHCP's will be co-produced with parents, but wondered if this might identify some parents who have learning disabilities themselves, and how they would be supported.

14.1.4 The Employment Sub Group is meeting with the New Opportunity Centre and Transport for London to develop a 'Travel Buddy Scheme'. The aim is to employ independent travellers to help other service users on public transport.

14.1.5 The Health Sub Group will be providing more training for GP's in the New Year. This will aim to continue to increase the number of people having annual health checks, and improve their outcomes by increasing referrals for health services and screening. Jon Robson (Service Manager Community Nursing) will be meeting with the CCG and Public health England to identify

People with Learning Disabilities in forensic units, to ensure they also have annual health checks and health action plans.

14.1.6 The community Nurses are working in partnership with One-to-One to deliver a Diabetes Group for people with Learning Disabilities. They have had their first session, and are focusing on lifestyle issues such as diet and exercise. The also provide training for staff. Weight Watchers are also working directly with One-to-One, and people can be referred to this free service directly by their GP's (information on this will be included in GP training in the New Year).

14.1.7 The Health sub group will also offer training (via the public health commissioner) to high street chemists about reasonable adjustments for people with Learning Disabilities.

14.1.8 The health sub group have also made excellent progress with the Winterbourne review. All 7 people identified have plans in place, and will be moving to more suitable services. DoH capital funding has been secured to develop local housing to facilitate this.

14.1.9 The Community Intervention Service has also been very successful in preventing people from accessing Assessment and Treatment Units. There were 1 800 'Bed Nights' a year used before it started, there have only been 30 since. Funding for this service has now been increased and extended for 3 to 5 years. This has been acknowledged by NHS England as an example of national best practice.

14.1.10 There has also been a programme for reducing the medication for people who are part of the Winterbourne review, which has also been cited as an example of national best practice.

14.1.11 The Health Sub Group also reported progress with the appointment of acute liaison nurses. Barnet and Chase Farm Hospitals have advertised for a full time post and will be interviewing soon. The North Middlesex Hospital will be advertising soon for a part time post, but there are ongoing discussions on the number of hours.

14.1.12 The Transition Implementation Group reports a new 'Transition Pathway to Employment' group will be meeting in November to set out a work plan. They are also working in partnership with the Skills for Work Service on a Study Programme, aimed at young people aged 18+ who are not eligible for Adult Social Care, but do not feel mainstream FE is for them. The new 'Transition Information Events Calendar' is now available; there will be 7 events this year. Ongoing Person Centred Transition Reviews Training is being provided for parents/carers and professionals by the SEND steering group.

14.1.13 The Services for People whose Behaviour can be Challenging sub group have completed the first part of the data set on peoples assessed behaviour. This focused on people using community services. This information

will help the group target training offered, and assess the quality of guidelines in place.

14.1.14 The board was also pleased to be informed that the Integrated Learning Disability Service has been given permission to recruit to 4.5 more social work posts.

14.1.11 The Board were also pleased that the Care Charging Policy will be revised so that people who use their respite creatively do not pay disproportionately high charges, and that individual arrangements will be made this year so that no families pay too much.

14.1.12 Wendy Berry (Cape), Niel Niehorster and Doug Wilson will meet to discuss ways to help people with Learning Disabilities understand Disability Related Expenses in relation to their Care Charges.

14.2 Carers Partnership Board

The Carers Partnership Board is now chaired by Rosie Lowman, the Commissioning Manager for Carers Services. Christie Michael is currently taking a break in her role as the Carer Co-Chair due to caring and health reasons. However it is expected she will return in early 2015.

The Board recently discussed how to improve its practice and influence and will be restructuring its meetings for 2015 – the Board will move from meeting every two months for two hours to quarterly for three hours. Membership has been refreshed and it is hoped the Board will improve its effectiveness in 2015.

14.3 Mental Health Partnership Board

No update available for this report

14.4 Older People Partnership Board

14.4.1.Integrated Care Update and Discussion

Paul Allen, Integration Programme Manager, Enfield CCG gave a comprehensive presentation on integrated care to date in Enfield. Integrated working has moved a long way since starting approx. 10 months ago, and GP engagement in this is very positive. The main agencies involved are GP's, Enfield Community Services (Health) and Adult Social Care, including Occupational Therapy. The Board were very positive about this development and have requested for Integration Update as a standing item on the agenda.

14.4.2 Dementia Pathways

A presentation on Dementia Pathways was delivered to the Board following a consultation exercise with local residents. Dementia navigators are planned

who will broker a range of appropriate dementia services. This was well received by the Board.

14.4.3. Data Sharing

This item is an update form the previous Board. Kate Robertson updated on shared data and discussed the privacy statement on the LBE website. KR informed on the 'My Enfield' portal, which will provide residents access to their single council record (i.e. housing, council tax), will be fully operational in the next 18 months, and the CCG will be looking to bring in a partner that can develop a system that brings NHS & Adult Social Care data in one place. The Board asked, if under the privacy statement, would organisations that are funded by the council be required to share information about their clients with the council. KR replied that these organisations will be governed by their own privacy statement. Kate agreed to come back in Jan to give a full update on Digital Customer.

14.4.4. Terms of Reference

The Board agreed the Terms of Reference require updating to ensure they are fit for purpose and the Board is clear on direction. A date for this has been agreed.

14.4.5. OPMH Sub Group Update

VM updated that the OPMH has recently reviewed it's Terms of Reference and have had 2 meetings since which has been positively received by its members. The meetings are now arranged by choosing a topic for discussion by the group. The previous topic for presentation and discussion was the RAID team at NMUH.

14.4.6. Pension changes

Dee Solanki, DWP, updated members of the changes to the State pension. DWP updates are now a standing item on the agenda.

14.4.7. 'Flu Jabs

Board members aired some concerns re: promotion of the 'flu jab in GP surgeries. This will be discussed with the CCG.

14.5 Physical Disabilities Partnership Board

14.5.1. Digital customer: aims of digital customer principles were presented and discussed with the group, and explained in terms of improving LBE l website where residents can inform the council of any changes of circumstances, personal changes, check eligibility and apply for services, which could be linked to their circumstances e.g. caring, and single view of customers, accessible information, right first time principles etc. this was generally well received and quelled a number of previously aired anxieties

from older residents. The Board requested frequent updates, and for further information on data sharing re: shared council accounts. This discussion links with mobile working, below:

14.5.2. Mobile Working / going digital: Margaret Brand, Enablement Manager, updated on how the use of digital devices for staff are working for both staff and service users. Margaret demonstrated how the device works and explained how this saves time for the worker. Enablement Workers now have smart phones and can report back to the main office remotely. These devices have helped worked find homes, parking and provide service users with information on services. A discussion around signing an electronic form followed, some members felt this was fine, while others would prefer to have a completed document in front of them (ie printed) and have time to agree the content before signing. Margaret explained that this is fairly usual and the service users is always listened to for their preference. A detailed and interesting discussion followed on digital apps etc that might be helpful for staff and users of services.

14.5.3. Transport - Norma McFarlane (Board Member, Carer) will attend the TfL focus group and feed back to members.

14.5.4. PD PB Christmas Gathering - Board Members discussed and agreed the need to attract a wider range of people onto the Board. A Christmas 'do' has been arranged and a number of young service users, their carers, health colleagues, and others, have been invited to this event where the purpose of the Board will be explained and new members can be identified. Following this event, the March Board will focus on updated ToR, structure of the Board and priorities for the year.

14.6. Enfield Safeguarding Children Board (ESCB)

14.6.1 There has been considerable national activity and reporting on the topic of Child Sexual Exploitation (CSE). ESCB, has been focusing on increasing our understanding of the local problem and planning action to effectively address it. A CSE 'Problem Profile' which will provide us with greater knowledge about prevalence of CSE and the vulnerabilities and risk factors for young people is in progress to compliment the work that is already being done through the TSEM (Trafficking, Sexual exploitation and and Missing) sub-committee and the MASE (Multi-agency sexual exploitation) group. The Problem Profile will inform the revised CSE Action Plan which will be implemented very soon and will be monitored by the board.

We are part of a North London cluster of Safeguarding boards that successfully bid for a programme of support on tackling CSE from MsUnderstood, a third sector organisation which aims to improve local and national responses to young people's experiences of gender inequality. The programme, which will be delivered in the New Year, will help us improve our strategic response to CSE and specifically ensure we have robust and effective links with key related initiatives such as the work being undertaken to tackle gang related activity.

Another priority from the business plan currently being focused on is Female Genital Mutilation (FGM). An important piece of research looking at prevalence and risk factors for girls in Enfield based on ethnic and cultural backgrounds has been completed by Public Health. Numbers of girls identified as being potentially at risk are significant and it is clear that work needs to be done both to raise awareness of this issue and to develop and implement strategies to tackle it. A further report will be completed early next year and a joint Public Health / ESCB Conference on FGM is planned for the spring.
The two Serious Case Reviews (SCRs) which ESCB have led on are now ready for publication. One has been completed jointly with Haringey and the other with Barnet and both concern young black males who were involved in gang-related violence. There are a range of recommendations and actions which will require the cooperation and support of partner agencies across the boroughs. A joint learning event is planned for April 2015 to disseminate and explore the learning

14.6.2. The Board has recently agreed its priorities for 2014-2016 with a streamlined business plan focussing on improvement outcomes. The priorities in the new Business Plan include:

- Tackling Domestic Violence, Neglect, Substance Misuse, Mental Health and Child poverty as well as Female Genital Mutilation. A key success factor for all of this work will be partnership working with other Boards and to this end; the ESCB has drafted a protocol which sets out the working relationships between Boards. This will ensure that the work is not duplicated, but rather that resources and expertise are maximised.

- This protocol is being discussed with each of the Boards and will be finalised once discussions are concluded.

14.6.3. The Young People's Board is now in place and will be working on key safeguarding projects including e safety and bullying. Representatives will be attending each of the ESCB main meetings – this will ensure that young people can play an active role in the work of the Board.

14.6.4. The ESCB website continues to play an important role in raising awareness about safeguarding both for those working with children, young people and their families, as well as the wider community. The Board is planning a media campaign to highlight the website and the information contained therein. The Community handbook has been launched and has been well received – this provides information primarily for the community on a wide range of safeguarding issues.

This can be found on the website at the following link: http://www.enfield.gov.uk/enfieldlscb/info/4/publications/226/enfield_community_handbook

Primary Care Premises Strategic Group

Terms of Reference

1. Purpose of the Group

- Provide long term strategic oversight to future developments based on a robust evidence base and needs analysis;
- Provide strategic oversight to current primary care premises developments in the borough;
- Identify premises 'at risk' due to leases nearing their end and factor this into the strategic planning;
- Explore options to overcome common challenges faced taking forward development schemes;
- Ensure a co-ordinated multi-agency approach to primary care developments, providing a forum for effective communication and ideas generation.

2. Context

The Council, NHS Enfield Clinical Commissioning Group, NHS England and NHS Property Services are keen to support the development of primary care facilities in the borough and ensure these are effectively planned and co-ordinated. A number of Project Boards exist for specific projects; however, there is not a single forum that brings together the key organisations, to facilitate a strategic approach to primary care premises developments.

Responsibilities for primary care services are shared across a number of organisations as follows:

NHS England NHS England commissions and holds contracts for primary care services directly. They carry out contract monitoring and make payments to practices for the services they provide to patients, including some reimbursement for practice overheads such as rent, rates and clinical waste. NHS England considers applications from practices for both capital and revenue primary care developments and is responsible for approving or rejecting Project Initiation Documents (PIDs), Outline and Full Business cases (OBC/FBC). The Clinical Commissioning Group Framework is designed to dovetail with these NHS England documents and ways of working.

NHS Enfield Clinical Commissioning Group has a key role in developing primary care capacity and quality, to enable it to reduce activity within acute settings. This includes providing advice and support to practices that are planning a move or major refurbishment and liaising with the other stakeholder groups involved. The Clinical Commissioning Group can signpost and help practices navigate the various statutory

agencies they need to work with in order to progress a primary care premises development project. In some cases the Clinical Commissioning Group may form a partnership with a GP practice in a primary care premises development project, to develop extra capacity for its care closer to home plans. Clinical Commissioning Groups are required to keep a Primary Care Premises Development Framework that provides information on the current capacity of primary care as well as predictions about future demographic growth and the impact on demand for primary care services. Clinical Commissioning Groups are not able to take on a lease but do have the capacity to provide assurance that it would commission a service from a provider and that the rent on the space would be guaranteed for a specific period of time if it chooses.

NHS Property Services is responsible for the management of all the former Primary Care Trust estate that has not transferred to NHS Trusts. This includes a role of landlord and a provider of property related support services. NHS Property Services provides strategic estates management advice on new capital projects, to ensure value for money and affordable development solutions are achieved. In addition, NHS England leads on new acquisitions and disposals on behalf of the commissioning bodies, where appropriate. On behalf of NHS England, NHS Property Services advises and manages the GP premises reimbursement process under the 2013 guidelines.

The London Borough of Enfield has an interest in the development of primary care services as part of its wider leadership role and is involved in significant regeneration schemes, which potentially provide opportunities for the development of primary care services. The local authority also has an important role in determining primary care premises developments as it now commissions public health services for practices and provides data to the Clinical Commissioning Group about demographic and epidemiological changes. The Council has an active role in the local Health and Well Being Board, which leads the development of Joint Strategic Needs Assessment.

In addition to the four organisations with an active role in this Group, the following organisations also have a role to play in the development of primary care premises:

NHS Trusts (Acute, Community and mental health) received a number of former Primary Care Trust premises on 1st April 2013, so is a significant local estate owner as well as being tenants in other buildings. The availability of this estate provides potential opportunities for developments within primary care, which may also generate efficiencies across the healthcare system.

Community Health Partnerships play a key role in leading public private partnerships to deliver a wide range of health planning and estate services that support health providers and local authorities to achieve improvements in the estate. They also own and are responsible for the operational management of Enfield's Forest Primary Care Centre LIFT building.

3. Group Membership

The Group membership is shown below. The Group will be chaired by the Director of Health, Housing and Adult Social Care.

Name	Role	Organisation
Ray James	Director of Health, Housing and Adult Social Care **(Chair)**	London Borough of Enfield
Bindi Nagra	Assistant Director Strategy and Resources	London Borough of Enfield
Neil Webster	Head of Strategic Property	London Borough of Enfield
Paul Walker	Assistant Director – Regeneration, Planning and Economic Development	London Borough of Enfield
Joanne Woodward	Head of Service – Strategic Planning and Design	London Borough of Enfield
Shahed Ahmed	Director of Public Health	London Borough of Enfield
Martyn Hill	Associate Director Estates and Facilities – North Central and North East London	NHS Property Services Ltd
Liz Wise	Accountable Officer	NHS Enfield Clinical Commissioning Group
Fiona Erne	Deputy Head of Primary Care – North Central and East London	NHS England

Where required interested parties may be invited to join a meeting for a specific agenda item. This may include but is not limited to the following:

- Public Health England
- Community Health Partnerships
- Other NHS Trusts.

4. Group Responsibilities

The Group will:

- Clarify the structure and roles for primary care improvement and premises development across the member organisations and ensure this is clearly communicated to relevant staff;
- Share information on key future priorities and examine on a partnership basis how each partner can help to progress those priorities on an affordable and value for money basis;
- Clarify the process for overcoming any conflict of interest issues that arise in the development of primary care premises
- Provide strategic leadership to the development of primary care facilities in the borough;
- Receive updates on each of the ongoing developments, so progress can be tracked in a single forum;
- Review common challenges faced in taking forward development schemes and explore options to overcome these within each organisation;
- Review premises profiles of primary care facilities in the borough (e.g. condition of premises, size, quality), to prioritise where attention should be focused;
- Identify where leases are coming to an end for primary care premises and explore alternative options at a strategic level;
- Review the needs of the borough and identify where additional primary care capacity is required;
- Explore the use of Section 106 or Community Infrastructure Levy funds to support the development of primary care/community facilities;
- Review the Council's regeneration plans and any opportunities to link these with the development of new primary care/community facilities;
- Allocate appropriate resources within each organisation to support the exploration of the business case for any potential developments that are identified;
- Foster collaborative working between the parties.

5. Group Member responsibilities

- Group members are required to attend the meetings or provide a deputy where this is not possible;
- Group members are required to pursue actions between meetings and report any issues to the Chair.

6. Governance

The Group will meet on a quarterly basis and be chaired by the Director of Health, Housing and Adult Social Care. In the absence of the Director of Health, Housing and Adult Social Care the Group will be chaired by the Assistant Director Strategy and Resources.

The Group will be administered by the London Borough of Enfield. Papers will be circulated five working days in advance of the meetings and minutes will be circulated within two working days following the meeting. All papers will be restricted and not circulated more widely without the prior permission of the Chair.

The Group will receive brief updates from the Project Boards of all developments underway, to initially include Joint Service Centre, Southgate Town Hall and Highmead.

Working groups will be established as necessary to progress more detailed work between meetings.

The Group will report to the Improving Primary Care Board, a sub group of the health and Wellbeing Board, as required.

7. Confidentiality

The Group will be required to engage in sensitive strategic and commercial discussions therefore the meetings will not be open to the public and all papers and discussions shall remain confidential, until agreed otherwise.

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Appendix 2

ORDNANCE UNITY CENTRE

PROGRESS UPDATE

The building is now in the final stages of construction.

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HEALTH AND WELLBEING BOARD (Appx 3)

Title	Section 75 Agreement (Adults) 2014 - 2015 Half Year Review
Author of Report	Jemma Gumble
Contact Details	X 2380 or Jemma.Gumble@enfield.gov.uk
Purpose of Report	To summarise the findings of the Section 75 Agreement half year review for 2014 - 2015. • For information
Executive Summary	In April 2014 the revised Section 75 Agreement for commissioned services for adults became operational. This report provides an update on the partnership arrangements between April – September 2014. Generally, the partnership arrangements are working well. However, there were significant delays in invoices being raised to Enfield CCG for Q1 and Q2 due to the implementation of ASH (a new debtors system) at the Council, meaning that payment is outstanding from the CCG for Q1 and Q2. The wheelchair service has not commenced and is expected to transfer at the start of the new Section 75 agreement in April 2015.
Recommendations	1. Note the content of the Section 75 Agreement half year review. 2. Note that due to delays in invoicing, payment is outstanding from the CCG for Q1 and Q2 as a result of Council systems. 3. Note that the wheelchair service did not transfer on 1st October 2014.

DRAFT

1. Introduction

In April 2014 the revised Section 75 Agreement for commissioned services for adults became operational. The table below shows the Schedules within the Agreement and the contribution of each Party.

Service	Pooled/Integrated/ Lead	NHS Enfield CCG Contribution	Council Contribution
Mental Capacity Act and Deprivation of Liberty Safeguards	Pooled & Lead	£70,908	£199,100
Joint Commissioning Team	Integrated	£50,259	£587,664.92
Voluntary and Community Sector	Lead	£409,907	£0
Integrated Community Equipment Service	Pooled & Lead	£401,715	£972,642
Public Health	Integrated	£0	£101,000
Integrated Learning Disabilities Service	Pooled & Integrated	£1,484,241	£3,970,850
Wheelchair Service	Pooled & Integrated	£776,168	£0
Personal Budgets for Health	Integrated	£24,000	£0
TOTAL		**£3,217,198**	**£5,831,256.92**

In line with the Agreement this report provides a half year review of each Schedule from April – September 2014, to provide an update on performance and the effectiveness of the partnership arrangements. Generally the partnership arrangements are working well. A key concern is the delay of invoices being raised to Enfield CCG for Q1 and Q2 due to the implementation of ASH, a new debtors system. However, invoices have now been issued for Q1, Q2 and Q3.

DRAFT

2. Mental Capacity Act and Deprivation of Liberty Safeguards

2.1 Overview of Schedule

The Local Authority Services Act (1970) outlines the requirement for the local authority to provide services to people of all ages with mental health problems in Enfield. The National Services Act (2006) states that NHS Enfield CCG is required to provide mental health services to people of all ages in Enfield and beyond. Whilst the responsibilities of the functions relating to the Supervisory Body of the Deprivation of Liberty Safeguards (DoLS) transferred to the Council, CCGs retain the statutory responsibilities for the practice under the Mental Capacity Act (MCA) 2005. NHS Enfield CCG needs to ensure that the organisation and all the services it commissions are compliant with the MCA. The MCA and DoLS schedule identifies a partnership arrangement which permits information sharing between the Parties and the delivery of specialist experience of delivering training and auditing services. This includes a Joint Safeguarding Nurse Assessor post to provide pivotal support for adult safeguarding and to ensure that the requirements for professional supervision are met.

2.2 Governance

The governance structure outlined in the Agreement is being followed. The service is continuing to be managed by the Head of Safeguarding Adults, Quality Assurance and Complaints at the Council, who reports to the Assistant Director Strategy and Resources. Decisions about running the service are being made by officers at the Council responsible for delivering the service.

Quarterly DoLS Reports are made to the Safeguarding Adults Board. The Safeguarding Adults Board was informed about the Supreme Court judgment in the case of P v Cheshire West and Chester Council and P and Q v Surrey County Council. This case caused severe implications for the increase on the demand for people who would now require assessments and a subsequent Deprivation of Liberty Safeguard. On 19 March, the Supreme Court published its findings and clarified the test and definition for Deprivation of Liberty for adults who lack capacity to make decisions about whether to be accommodated in care. This means that a much greater number of service users and patients will now be subject to a deprivation of liberty and will come under the protection of the DOLS procedure.

2.3 Financial

The contributions in the Agreement total £270,008. To date £58,929 has been spent.

In response to the influx of applications (predicted nationally to be a ten-fold increase) the Enfield DoLS Office had to respond by enhancing resources to try and manage these statutory responsibilities as best as possible. An additional administrator post and two Best Interest Assessors' Posts were created in the short term and agency staff members recruited. London Borough of Enfield have submitted funding proposals and an action plan to the Directorate Management Team and Cabinet to notify them of the matter and ask for more resources to manage this successfully. A request for additional funding is also being prepared

nationally to submit to the Department of Health. The NHS have been supporting CCGs with grants for special projects to help raise awareness amongst staff with regards to the Mental Capacity Act 2005.

2.4 Key Achievements

- Enfield DoLS Office has completed assessments on 203 Applications out of the 252 DoLS applications received during the period 1 April 2014 – 30 September 2014; with 179 DoLS authorisation being granted.
- Enfield DoLS Office was consulted by the Court of Protection to help streamline their new judicial Deprivation of Liberty processes and forms. They are equally having difficulty managing their workload following the influx of cases since the Supreme Court Ruling.
- The Safeguarding Adults Board was supported in the application for a £9000 grant from the NHS to help raise awareness on the MCA & DoLS, which was successful.

2.5 Key Challenges

The main challenge remains to manage the hundreds of DoLS Applications received since the Supreme Court Ruling. Like all councils in the country London Borough of Enfield is not meeting the legal timescales on all cases, but continues to make every effort to do so.

2.6 Key Priorities before 31st March 2015

- Continue to make a contribution on behalf of all London Boroughs at the National ADASS Task Force that has been established to develop ‘Top Tips’ for managing the influx and a review of the DOH DoLS Forms, following the Supreme Court Ruling.
- To continuously manage the Deprivation of Liberty Safeguards applications to a high standard, by involving the person, their relatives and friends and issuing the Safeguards when necessary to keep the person safe.
- To train more and eventually all of the suitable professionals in the workforce to become Best Interest Assessors.
- To produce a video for carers, health and social care professionals; to help raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards so that all people that need this level of protection has a Deprivation of Liberty Safeguard in place.

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3. Joint Commissioning Team

3.1 Overview of Schedule

The Schedule establishes a Joint Commissioning Team across health and social care which seeks to work in partnership to manage an increase in demand against diminishing resources.

3.2 Governance

The Assistant Director Strategy and Resources is responsible for the joint commissioning function. Joint commissioning activity continues to be reported to the Joint Commissioning Board, a sub group of the Health and Wellbeing Board. The Joint Commissioning Board was suspended over the summer period while resources were diverted to the development of the Joint Better Care Fund plan which was considered as a priority project.

3.3 Finance

The contributions in the Agreement total £637,923. To date, £232,024 has been spent by the Council. There is a variation in the budget which has been due to restructuring, recruitment to vacant posts and maternity leave. One post remains vacant at present. However, the projection to year end is that the budget will be fully spent.

3.4 Key Achievements

- The Joint Adult Mental Health Strategy has been agreed and is now in the process of being implemented. We currently do not have a Joint Mental Health Strategic Commissioner in post.
- The Joint Adults Autism Framework has been agreed and is being implemented over a two year period. The CCG and Local Authority are working together to establish a local diagnostic and therapeutic support service for people with high functioning autism (i.e. Asperger Syndrome).
- The successful recruitment to the joint commissioning posts. We have also recruited to Procurement and Contracts Services which are both considered as valuable resources to support the delivery of the Joint Commissioning Team.
- Reductions in usage of assessment and treatment services for people with learning disabilities and local implementation of the Winterbourne View transformation programme. Enfield is being acknowledged as a centre of best practice by NHSE.
- Work is underway to modernise day opportunities and achieve efficiencies for those with Learning Disabilities. This includes people who are eligible for CHC.
- The pilot for implementing Direct Payments in Residential Care continues with DP’s already in place for respite care. Learning will be extended to Personal Health Budgets.

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- The ongoing work to support carers to continue in their caring role which includes direct payments for respite and outcomes focussed support planning. The success of the Care Home Carers Network.
- The Council and Enfield CCG have formed a partnership to jointly commission a range of community health services. Whilst the Commissioning Support Unit (CSU) are managing the procurement process, members of the Council's adult social care Commissioning and Procurement function are providing the benefits of specialist support, advice and guidance on strategic and technical procurement matters and ensuring that the Council's own internal contracting and procurement policies are complied with.
- Joint Commissioning Reports have routinely been submitted to the Public Health and Wellbeing Board sessions. These are well received.
- The Joint Learning Disabilities Commissioner continues to improve services for people with disabilities. In particular, they have been successful in reducing the need for NHS inpatient beds for people with learning disabilities at Seacole Unit and have also responded well to the requirement of the Winterbourne View Concordat in reducing NHS placements outside of Enfield.

3.5.1 Key Challenges

- New Commissioners need to embed in the Joint Commissioning Team to enable us to deliver our ambitious joint commissioning work programme.
- To review the Terms of Reference for the Joint Commissioning Board to ensure that it is focussed on identifying opportunities across health and care to generate efficiency, integration and closer joint working.
- On-going vacancy within the team to cover increased work requirement.
- The implementation of the Care Act from April 2015 which is the most significant reform in care since the National Assistance Act.
- Implementing the agreed Better Care Fund plan and programme.
- The requirement to manage and achieve substantial efficiencies across all Care Groups in both Enfield Council and the CCG.
- The need to restructure the VCS provision to meet the requirements of Enfield, the Locality model and the Care Act and improve quality, safety and efficiency.

3.6 Key Priorities before 31st March 2014

- To implement the Care Act from April 2015
- To implement the agreed Better Care Fund programme.
- To manage and achieve substantial efficiencies across all Care Groups in both Enfield Council and the CCG.
- To restructure the VCS provision to meet the requirements of Enfield and the Care Act and achieve efficiencies of provision.

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4. Voluntary and Community Sector

4.1 Overview of Schedule

Under this Schedule the Council obtained the responsibility for commissioning 10 services from Voluntary and Community Sector (VCS) organisations on behalf of Enfield CCG.

4.2 Governance

There have been no changes made to the governance structure since the production of the Agreement.

4.3 Financial

The 10 contracts equate to a value of £409,907. To date, £204,953.50 has been spent and the remaining £204,953.50 will be paid when invoices are received from the organisations in Q3 and Q4.

4.4 Key Achievements

- Signed Service Level Agreements are in place with defined service aims, objectives, outcomes, terms, conditions and performance management arrangements.

- There are now consistent payments, monitoring and performance management requirements across health and social care, which has resulted in process and transactional efficiencies for both commissioners and providers.

- Positive feedback has been received from the VCS as a result of the approach to co-produced service level agreements and a consistent single point of monitoring and payment.

- Payments are being made quarterly in advance, subject to the production of monitoring data which is avoiding a lengthy time lag between service delivery and payment and enabling VCS organisations to remain viable.

- Service is being targeted appropriately to the health and social care needs of the local population demographics.

- Prior to the Section 75 Agreement the Service Level Agreements (SLAs) included generic descriptions, focusing on outputs only and had expired. The transfer of commissioning responsibility via the Section 75 Agreement has provided the opportunity to review the commissioning approach and resulted in new SLAs which contain individual service user outcomes, together with outputs, targets and key performance indicators. All the SLAs were co-produced with the voluntary and community sector organisation.

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- Where appropriate, SLAs to cover both LBE and CCG funding have been combined, which has resulted in consistent monitoring and performance management requirements, process and transaction efficiencies and consistent user experience.

- Analysis of monitoring to date has revealed an overall compliance with specified requirements and delivery against targets.

- Through analysis of monitoring returns, an overall improvement of all providers reaching and exceeding the 100% mark for their outcomes has been noted.

4.5 Key Challenges

- Uncertainty of longer term funding arrangements restricts the degree of service development and innovations.

- The availability of resources within LBE to continue to be able to validate monitoring returns for the 10 contracts, without any additional management funding through the Agreement.

4.6 Key Priorities before 31st March 2014

- To seek continued commitment from the CCG for continued funding of these services and supports.

- To align funded provision with the adult social care strategic commissioning framework and the Better Care Fund

- To ensure service aims, objectives, outcomes and targets are achieved through regular monitoring of service provision.

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5. Integrated Community Equipment Service

5.1 Overview of Schedule

In line with the NHS and Community Care Act 1990, National Assistance Act 1948 and the Chronically Sick and Disabled Persons Act 1970, the Council and CCG provide an Integrated Community Equipment Service.

5.2 Governance

The ICES steering group meets monthly to monitor spend, trends and to address challenges. The delivery and performance KPI's are monitored monthly within Provider Services, with data escalated via departmental financial scrutiny and performance monitoring processes as required.

5.3 Financial

The contributions in the Agreement total £1,374,357. To date, £852,616 has been spent by the Council.

There has been an increase in demand for more complex equipment such as pressure care, hospital beds and hoists associated with discharge of patients with more complex needs into the community.

In order to address the growth in spend in this area recycling activities have increased and panel agreements have been introduced for spends over levels agreed within ICES steering group.

5.4 Key Achievements

- DTOCS linked to equipment are very low.
- P1 performance continues to be high.
- Positive action has been taken to address increase in spend
- The service has recruited a permanent manager.

5.5 Key Challenges

- Introduction of CM 360 system has been delayed by provider (MSoft), however implementation remains on course for the end of the financial year.

5.6 Key Priorities before 31st March 2014

- Facilitate the integration of NHS Wheelchair Services into Integrated Community Equipment Service.

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6. Public Health

6.1 Overview of Schedule

On 1st April 2013 the Public Health function transferred to local authorities. As part of this the Council commissions and monitors three LES contracts with local GP Practices. However, it is problematic for the GPs to receive payment directly from the Council therefore the schedule formalises the transfer of funding for three specific contracts to NHS Enfield CCG so payment can be made via the Commissioning Support Unit through NHS Enfield CCG's core offer.

6.2 Governance

The responsibility for Healthchecks and Sexual Health contraception has been transferred to local authorities. Payments to GPs are being made through the Enfield CCG ISFE payment in order to protect GP superannuation and pensions. The contracts are being monitored by the Council.

6.3 Financial

An indicative breakdown of payments is below:

Public Health Service (previously known as Local Enhanced Service)	2014-14 Projected budget
Healthchecks	£46,000
IUCD contraception	£26,000
Nexplanon	£29,000

Payments are being made to Enfield CCG on receipt of recharge claim as GPs are receiving payment for submissions.

6.4 Key Achievements

- 8411 Healthchecks were undertaken in 2013/14.
- Learning Disabilities and Diabetics reference are attached to the general Healthchecks services specification, ensuring that a larger section of the borough's population are now included.
- Both sexual health service specifications have been reviewed and redrafted.
- Relationship with GPs has improved via GP forums and the Healthchecks and Sexual Health links with GPs.

6.5 Key Challenges

- Obtaining monitoring information from the GPs.

- Receiving returns for GPs regarding their commitment to delivering the services. However, it has transpired that no response does not mean that they are no longer willing to deliver the service.
- Increasing the number of long- acting reversible contraception (LARC) implementations via GP practices

6.6 Key Priorities before 31st March 2014

- 2014-16 Contracts to be signed off by lead GP's
- Training for GPs on LARC

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7. Integrated Learning Disabilities Service

7.1 Overview of Schedule

This Schedule formalises the arrangements for an adult specialist learning disability service which covers both health and social care services.

7.2 Governance

The Integrated Learning Disabilities Service reports to the Health and Wellbeing Board through the Learning Disabilities Partnership Board and Joint Commissioning Board. At an operational level, the service is managed within the management structure of the Adult Division of Health, Housing and Adult Social Care. The service has monthly financial and performance reporting

The service has a management and clinical governance structure including clinicians and managers. An external GP provides additional clinical advice to the governance meeting. Clinical governance feeds in to the ECS/BEH and CNWLFT clinical governance structures. The ILDS reports to the CCG's LD Steering group and has a governance reporting line to the CCG Clinical Quality Committee.

7.3 Financial

The contributions total £5,445,091 in 2014-2015. To date, £2,365,754 has been spent.

7.4 Key Achievements

There have been a number of significant achievements in the year 2014/5 to date. These include:

- Significant reduction in the Assessment & Treatment bed days used in 2014/15 due to the establishment of the community intervention service which was funded as a pilot from March 2014.
- Application for £1.45 million from the Department of Health capital funding for the Winterbourne programme. Decision if bid has been successful was due at beginning of November.
- Application to take part in NHSE's integrated personal commissioning programme which will see people with learning disabilities given the opportunity to access fully integrated personal budgets (Health and Care).
- Working closely with Continuing Healthcare team to develop a pooled budget of resources that considers staffing as well as funding which we are hoping to present at the beginning of 2015.
- Working with primary care to improve the uptake up of DES Health Checks for people with learning disabilities (62%).
- Enfield is fully compliant with the Winterbourne view concordat and we have been highlighted as a centre of excellence by NHSE for our local implementation of the transformation programme so much so that we have been included as an example on Simon Stevens' (Chief Executive, NHS England) report on the programme.

- High numbers of people (NI145 at 77.2%) being supported locally in the community with exceptionally low numbers of people in OATS.
- 1 permanent residential placement made in this financial year to date.
- Shared electronic record implemented.
- Achieved £700k of care purchasing savings to date with a projected further £800k to be achieved in 2014/15.
- Consistently achieved very good standard in safeguarding, achieving excellent in many areas.
- Excellent user & carer engagement

In addition the ILDS is on track to achieve all its performance targets for 2014/15. There has been a delay in progress with regard to D40 review, but an action plan has been implemented and is now projected to achieve target.

Description	Target 14/15	At 30.09.14	Projection
NI130 Self Directed Support (snapshot)	99%	99.8%	100.0%
NI130 Direct Payments (snapshot)	Target equates to 180 clients	165 clients	180 clients
NI132 Timeliness of assessment (28 days)	90%	92.9%	92.9%
D40 reviews	82%	28.7%	82%
NI145 people with LD in settled accommodation	79%	77.2%	79%
NI 146 People with LD in Paid Employment	148	145	151
NI135 Carers Assessments	48%	24%	78.0%
C73 New admissions to Residential care	4 max	1 client	4 clients

7.5 Key Challenges

- Due to the success of the community intervention service, namely reduction in assessment and treatment usage, we have been informally notified by executive managers at CNWLFT that they are considering the longer term

viability of the Seacole service and may issue notice of termination. Commissioners are working together to develop contingencies and use of alternative provision. However, we are committed to providing services for people with learning disabilities in the community in which they live.

- Achieving significant savings whilst continuing to provide effective services.

- Lack of LD acute liaison nurse function at North Middlesex University Hospital.

- Significant increase of people with learning disabilities being referred to Enfield from out of borough. This has a significant impact on the local community team and health care in the borough. It also means that we have an uncontrolled population accessing assessment and treatment services.

- Increased number of people deemed to be no longer eligible for CHC placing the financial pressure to the LA.

7.6 Key Priorities before 31st March 2015

Continuing priorities for 2014/15 include:

- Increase numbers of people with learning disabilities on personal health budgets.
- Develop a cost and quality benchmarking resource across Health and Adult Social Care (Joint Performance System).
- Continue implementation of the Winterbourne View programme.
- To consider the inclusion of LD psychology services within the Sec 75
- Increase the numbers of people on direct payments.
- Identify and achieve further savings and achieve balanced budget
- Maintain reduced use of in-patient Assessment & Treatment beds and length of stays.
- Reduce the time from safeguarding alert to closure where possible and ensure effective oversight of longer term complex safeguarding investigations.
- Maintain excellent performance in PIs

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8. Personal Health Budgets

8.1 Overview of Schedule

Personal Health Budgets (PHB) are aimed at people who are already receiving NHS Continuing Care, who have a right to ask for personal health budgets from April 2014**.** A requirement for the Local NHS to provide appropriate and adequate support for those on personal health budgets came in to effect from April 2014.

8.2 Governance

This Project reports to the Joint Commissioning Board a sub group of the Health and Wellbeing Board.

8.3 Financial

The funding is being used to support the current work and the work going forward moving to integrated Health and Care personal budgets.

8.4 Key Achievements

- 12 Personal Health Budgets have been implemented since April 2014
- The CCG & Council are working in partnership to deliver a further 25 Personal Health Budgets. These PHB have been commissioned using MySupport Broker and work is now underway to work with the Councils Brokerage service to provide the same function as part of the integration.

8.5 Key Challenges

- Change of culture for organisations, service users and families in the move to Personal Health Budgets

8.6 Key Priorities before 31st March 2014

- Put in place the further 12 /13 Personal health Budgets.
- Provide a greater integration of the Brokerage Services both internal and external to facilitate this.

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9. Wheelchair Service

9.1 Overview of Schedule

An Integrated Community Equipment Service has been in place for a number of years across Enfield Council and NHS Enfield Clinical Commissioning Group. Currently the wheelchair service is not included within the integrated service and NHS Enfield Clinical Commissioning Group hold a separate contract for this service.

In order to benefit from economies of scale and provide a more streamlined service for service users and carers, it was proposed that the wheelchair service transferred to the Integrated Community Equipment Service on 1st October 2014. However, this has now been delayed due to the assessment of wheelchair stock held by the existing provider.

9.2 Governance

The governance for the Wheelchair service will be as outlined in the Integrated Community Equipment Service schedule.

9.3 Financial

The existing contract value is £776,168. NHS Enfield Clinical Commissioning Group will therefore contribute £776,168 per annum for the wheelchair service to the wider Integrated Community Equipment Service Pooled fund. As the transfer has not taken place, the 2014-15 contribution will be revised to reflect this.

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MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **11 December 2014**	**Agenda - Part: 1** | **Item: 6c** **Subject: Primary Care Strategy for Enfield** **Wards: All**
	Cabinet Member consulted:
	Approved by:

Dr Mo Abedi, Chair
NHS Enfield CCG
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1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on work to date to implement the Primary Care Strategy across the borough of Enfield.

The Primary Care Strategy project team reports jointly to the CCG Primary Care Strategy Implementation Board and the Health and Wellbeing Board.

2. RECOMMENDATIONS

The Enfield Health and Wellbeing Board is asked to note the contents of this report.

3. BACKGROUND

The Prevention and Primary Care Strategy (PCS) is one of six major programmes that support the transformation of healthcare in Enfield. Its aim has been to improve access to primary care services, improve patient experience and reduce variation in care for the population of Enfield.

2014/15 is currently anticipated to be the third and final year of the Strategy and as such will look to consolidate the successes of the first two years to ensure on-going sustainability. The main areas of have been:

- Integration
- Enhancing and improving health outcomes, access, patient experience and quality.

However, there have been a number of strategic developments published recently that will have significant impact on the direction of travel for primary care in the months and years to come.

4.0 Strategic Developments

4.1 NHS Five Year Forward View

The NHS Five Year Forward View was published on 23rd October 2014 and sets out a vision for the future of the NHS.

It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

4.2 Better Health for London

This London Health Commission report published on 15th October 2014, provides a set of ambitions and recommendations for London comprising aspirations for it to become the world's healthiest major global city - it is currently seventh behind Hong Kong, Tokyo, Singapore, Madrid, Paris and Sydney.

The report contains sixty-four recommendations grouped into five key themes:

1. Better health for all
2. Better health for London's children
3. Better care
4. Maximizing science, discovery and innovation to enhanced economic growth
5. Making it happen

All the bodies named in this report are asked to respond by the end of November, following which it is recommended that the Mayor convene and personally chair a group to prepare a unified delivery plan. It is anticipated

that this group would then continue to oversee progress in the implementation of the recommendations in this report.

4.3 Primary Care Commissioning Strategic Framework

NHS England's (London Area Team) Primary Care Transformation Board was established in April 2014 to develop joined up thinking on primary care commissioning strategies across London and to look at the implications of the draft GP Development Standards as a potential catalyst for change to support local primary care strategies.

To date, the work has included the oversight of a series of pre-engagement activities through focus groups, patient charities, a clinical challenge panel, feedback from Londonwide LMCs and contributions from academic and educational organisations.

As a result of pre-engagement, it was acknowledged that the term 'GP Development Standards' was not the best description of the three areas of **Accessible** care, **Co-Ordinated** care and **Proactive** care which most resonated with those involved in the pre-engagement phase. The three areas are seen as a specification within a strategic commissioning framework which describes the service offer that patients could expect in the future across London. It acknowledges that implementation plans will need to be locally developed to meet the needs of different populations. It is anticipated that working to this specification will relieve pressure and enable general practice to deliver improvements in care.

The Primary Care Strategic Commissioning Framework will be reviewed for the final time in October in preparation for wider engagement from 26th November 2014 to include a vision for primary care in the future, specification of the service offer in the three areas and a summary of the findings of the following enabling workstreams:

- Workforce implications
- Financial implications
- Technology enablement
- Monitoring and evaluation
- Commissioning development
- Potential models of care and GP Provision.

4.4 Next Steps for Co-Commissioning of Primary Care Services

On 10th November 2014, NHS England published guidance which:

- clarifies the parameters of each of the three co-commissioning models: i.e. greater involvement, joint commissioning arrangements and delegated commissioning arrangements,
- describes the opportunity to design a local incentive scheme, as an alternative to QOF or DES'
- gives CCGs the opportunity to choose afresh the co-commissioning model they wish to assume; and

- describes arrangements for implementation, including governance, managing conflicts of interest, the approvals process and ongoing assurance.

The NCL Primary Care Leads Planning Group met for the first time on 12th November 2014 to oversee and provide strategic direction to the delivery of this work programme and the rollout of the Primary Care Commissioning Strategic Framework.

Process and timeline:

CCG and NHS England London Area Team work together to further develop delegated commissioning proposals	12th November to January 2015
Formal launch of Primary Care Commissioning Strategic Framework	26th November 2014
Engagement with London Borough of Enfield on Primary Care Commissioning Strategic Framework and co-commissioning submission	December 2014 → January 2015
Review of NCL co-commissioning submission by NCL Clinical Commissioning Committee	January 2015
Submission of proposal for joint arrangements and constitutional amendment	30th January 2015
Regional moderation panel review of proposals and recommendations for approval made NHS England Clinical Commissioning Committee approves proposals	February 2015
Subject to approval, NHS England's finance directorate arrange the transfer of delegated budgets and CCG's informed of the outcome of their constitutional amendment request	March 2015
Arrangements implemented in full locally	From 1st April 2015

Once proposals are approved, CCGs will need to set out their plans, as per the 2015/16 planning guidance to be published in December 2014, to be implemented from 1st April 2015.

5. SERVICE DEVELOPMENTS

5.1 Diabetes

From 1st December 2014, GP Practices located within South East locality will pilot an integrated diabetes primary care initiative over a six month period. The service aims to deliver additional resources to practices working within the South East locality to provide high quality, patient-focused care to patients with Type 2

diabetes and to ensure that patients receive the same, high standard of care regardless of the Enfield practice from which they seek care.

The practices are to be commissioned to:

- Undertake personalised care planning for newly diagnosed patients and patient with complex care management needs; and
- To work collaboratively within a multidisciplinary approach to ensure patients with complex care needs received specialised and personalised care packages.

The three key broad outcomes proposed are:

- To see an improvement of HbA1C levels across the South East locality
- To see an increased uptake rate on care planning across South East locality

Practices will be supported by the Enfield Community Diabetes Service and local Consultant Diabetologist(s) through shared learning and mentoring arrangements at a practice level. We believe this commissioned service will offer opportunities for practices to work collegiately on the delivery of diabetes scheme.

5.2 Enhancing Cardiology

From 1st December 2014, GP Practices located in the South East will be commissioned to deliver a pilot service in enhancing cardiology in primary care.

The service is in two parts. The first part is to conduct a retrospective audit to ascertain causes at individual and population level for acute cardiovascular events in Enfield. This will inform the development of network based Cardio Vascular Disease (CVD) care packages in Enfield for 2015/16.

The second part is to focus on piloting a primary care Atrial Fibrillation (AF) service which will work across the health system to promote a systematic approach to reducing the incidence of stroke in Enfield. The approach would be to build systems and capacity to address the major risk factors for stroke.

The enhancing cardiology in primary care project has been funded by Enfield Public Health and Enfield CCG and forms part of a wider review of cardiology within Enfield and its objectives are:

- To integrate a clinical decision support tool into each Enfield GP practice.
- To improve QoF AF prevalence rates, and achieve QoF targets, by integrating alerts and standard data entry templates in all primary care systems in Enfield.
- To promote opportunistic screening initiatives in GP practices to identify and target Enfield-specific at risk populations for AF screening.
- To provide all GPs with best practice information on the management of AF and appropriate local anti-coagulation pathways.

To deliver:

- Improved clinical management of patients with AF
- Reduced incidence of stroke
- Reduction in treatment costs for stroke
- Adherence to knowledge based best practice clinical guidance

6. REASONS FOR RECOMMENDATIONS

To update the Health and Well Being Board of the opportunities for strategic development of primary care in Enfield and two specific areas of service development to be piloted in order to enhance and improve health outcomes.

7. CONCLUSION

This report provides an update on progress of the Primary Care and Prevention programme.

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 16 OCTOBER 2014

MEMBERSHIP

PRESENT Shahed Ahmad (Director of Public Health), Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Deborah Fowler (Enfield HealthWatch), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Litsa Worrall (Voluntary Sector), Vivien Giladi (Voluntary Sector), Donald McGowan, Rohini Simbodyal, Ayfer Orhan and Mo Abedi (Chair of the Enfield Clinical Commissioning Group)

ABSENT Ian Davis (Director of Environment), Dr Henrietta Hughes (NHS England) and Doug Taylor (Leader of the Council)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Allison Duggal (Public Health Consultant), Tha Han (Public Health Consultant) and Alan Winstanley (Better Care Fund Programme Manager) Penelope Williams (Secretary)

Also Attending: Stanley Okolo (Medical Director & Consultant Gynaecologist at North Middlesex University Hospital)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting.

Apologies for absence were received from Dr Henrietta Hughes, Councillor Doug Taylor and for lateness from Vivien Giladi and Councillor Rohini Simbodyal.

2
DECLARATION OF INTERESTS

There were no declarations of interests.

3
CHANGE IN THE ORDER OF THE AGENDA

Members agreed to change the order of items on the agenda so that item 7 could be bought forward to be taken at this point. The minutes reflect the order of the agenda.

4
BOARD MEMBERSHIP

The Board received the report proposing an increase in the Board Membership, the appointment of a Vice Chair and an amendment to take account of the change cabinet member titles and remits.

NOTED

1. The title of the Director of Public Health also needs to be changed as it is included in the Board terms of reference as the Joint Director of Public Health.

2. It was felt that the roles of the cabinet members that are appropriate to the board would always be those that are similar to the current members. Therefore it was proposed that the membership should be changed to reflect the change in the cabinet member titles, which had occurred since the terms of reference were originally agreed. These would need to be altered again if further changes occurred.

3. The recommendation to appoint non-voting members at a senior level from the 3 NHS providers was welcomed.

4. The length of the voluntary sector representatives' term of office was thought to be three years but would be confirmed after the meeting. This information would be included in the terms of reference.

AGREED

1. To agree and recommend that Council approve the following changes to the board membership and terms of reference:

1.1 To authorise the creation of a vice chair to be filled by the Chair of the Enfield Clinical Commissioning Group.

1.2 To grant board membership, without voting rights, to each of the three local NHS trusts as providers of health services in Enfield: the Royal Free London NHS Trust; North Middlesex University Hospital NHS Trust; Barnet, Enfield and Haringey Mental Health NHS Trust.

1.3 To alter the membership of the Board from the four Cabinet members listed in the terms of reference, to the following:

- Leader of the Council
- Cabinet Member for Health, Housing and Adult Social Care
- Cabinet Member for Education, Children's Services and Protection
- Cabinet Member for Culture, Sport, Youth and Public Health

1.4 To alter the title for the Director of Public Health, as listed in the board membership, from the Joint Director of Public Health to the Director of Public Health.

1.5 To include the length of the third sector representatives' terms of office.

Post Meeting Note: The third sector representatives had been elected to serve for a three year term from April 2013.

5
BETTER CARE FUND

The Board received an update on the Better Care Fund Plan Submission and Governance Arrangements.

NOTED

1. Ray James's apologies for the late dispatch of the report which had been delayed as officers had hoped to be able to finalise the proposals on the governance arrangements, but this had not been possible.

2. The suggestion that consideration of recommendation 2, 3 and 4 be postponed to give more time to enable the board to discuss at a development session.

3. The target 3.5% yearly reduction in hospital admissions should be highlighted as a risk as part of the financial implications to the report. This will be difficult to achieve particularly as the borough population is rising so fast.

4. It was felt that the aims were excellent but that they would be difficult to deliver.

5. It was suggested that the council and the CCG should consider integrating other health and social care budgets. This would be subject to further discussion at a development session. The Better Care Fund represents only 3% of the total health budget, but is part of a much greater ambition for service integration.

AGREED

1. To note that the Better Care Fund Plan was submitted by the 19 September 2014 as detailed in Annex 1 to the report, having been approved on behalf of the Board by the Chair under delegated authority. The contents of the plan are included in Annex 1 of the report.

2. Recommendations 2, 3 and 4 of the report would be subject to further discussion at a board development session.

3. The board would continue to receive regular progress updates.

6
CCG OPERATING PLAN, CCG COMMISSIONING INTENTIONS FOR 2015/16 AND NORTH CENTRAL LONDON STRATEGIC PLAN

The Board received a report on the CCG Commissioning Intentions, CCG Operating Plan and North Central London Strategic Plan.

1. Presentation of the Report

Graham MacDougal (Director of Strategy and Performance) presented the report to the Board highlighting the following:

- He apologised for the late paper. There would be two versions a full version and an abridged version for key stakeholders.

- The CCG is also developing an Enfield specific public facing prospectus including the themes from the 5 year North Central London (NCL) Strategic Plan and the CCG Commissioning Intentions.

- Patient scenarios and patient stories will be included in the prospectus.

- The commissioning relationship with the local authority will be open to wider development in the future.

- It was the aim of the CCG to engage with all local GP practices when commissioning to reflect the different needs and populations in the different areas.

- Following the initial submission, the 5 NCL CCGs had been asked to strengthen the 5 year financial plan and the plans for the delivery of a range of initiatives.

- Governance arrangements across the five CCGs are still subject to discussion. Consideration is being given towards the creation of joint boards.

2. Questions/Comments on the report

2.1 The new contract starts in October 2015. There will be challenges with the delivery and discussions have already begun with the local authorities involved. If the mental health trust is not part of the new provision there will be a 90 day consultation period with the staff.

2.2 It was felt that the patient experience was key to driving change. Each programme and initiative should include patient engagement. All engagement was being bought together to ensure that there is focus on the patient experience in improving the quality of services.

2.3 Outcomes based quality was a fundamental part of the improvement programme.

2.4 There will be a focus on improving the mental health and wellbeing of the patients in Enfield. Recovery enablement was being considered. It was felt that an extra bullet point should be added to the report to specify improving the mental health of young people.

2.5 Outcomes will need to be defined, measured and agreed.

2.6 How to work with mental health issues was being considered.

2.7 It was also suggested that the need for ensuring resilience in service quality during times of major change should be included.

AGREED

1. To note the progress to date on the development of the North Central London Strategic Planning Group five year plan.

2. To note the update on the NHS Enfield CCG Operating Plan.

3. To note the revisions to the NHS Enfield commissioning intentions for 15/16.

7
ADULT AND CHILD SAFEGUARDING ANNUAL REPORTS

The Board received the annual reports of Children's and Adults Safeguarding Boards.

1. Presentation of the Safeguarding Reports

1.1 Marian Harrington (Independent Chair of the Adult Safeguarding Board) and Geraldine Gavin (Independent Chair of the Children's Safeguarding Board) attended the meeting to present the reports to the Board.

Marian Harrington presented the Adult Safeguarding Annual Report and highlighted the following:

- There had been an increase in the number of abuses reported to the board: last year nearly 1000 alerts were received. These are increasing year by year.
- New statutory guidance is about to be released, coming out of the Care Act 2014, which will make the Adult Safeguarding Board statutory. Changes will be made, but the details would not be clear until the guidance was received.
- The Board works closely with the police and other agencies.

- Enfield has a significant number of nursing homes, more than any other London borough, apart from Croydon, which means we have larger numbers of vulnerable people.
- Early warning indicators are being developed, specifically for Enfield, in conjunction with the Care Quality Commission (CQC) and Enfield Clinical Commissioning Group (CCG).
- The Board has been talking to victims and alleged victims to get some feedback on what can be done to improve services, making sure people are at the centre of what is being done.
- The number of requests for Deprivation of Liberty Safeguards for people lacking mental capacity is much greater than was previously understood.
- Workloads are increasing in all areas and it is more and more important to ensure that people are seen appropriately.

1.2 Geraldine Gavin presented the Children's Safeguarding Report highlighting the following:

- Children's safeguarding issues are receiving lots of attention, subject to daily comment in the national press.
- This has been a tricky year trying to balance the effect of the national headlines as well as the reputational risk of safeguarding issues.
- Female Genital Mutilation has received a great deal of publicity thanks partly to the campaign in the London Evening Standard which has bought the issue to the fore.
- The major child sexual exploitation case in Rotherham had also raised many concerns and the lessons and outcomes are being considered.
- In Enfield we have 30-35 young people who have been identified as potentially at risk. They were being monitored.
- Multi-disciplinary work was taking place and work to improve communications across the partnership.
- Communication, learning from serious case reviews and from other health colleagues was key.
- A major concern was the lack of access to counselling for young people with mental health issues.
- It had been a very busy year and would continue to be so next year with the issues being so much in the political arena.

2. Questions/comments arising from the presentation and the reports

2.1 The point at which the increase in the number of cases becomes more than reassuring, as an indicator that that more people are alert to the risks, is difficult to ascertain but can be judged based on existing thresholds. Ofsted is key to ensure consistency. Enfield is likely to be inspected soon and outcomes from the inspection will inform the board about any measures that need to be taken.

2.2 The Board were aware of the need to find alternative sources of funding to address the continuing pressures across the system.

2.3 Things were improving but more needed to be done in the adult safeguarding area. Financial abuse was a problem and work with banks was taking place so that they were able to identify situations where people may be being exploited.

2.4 Crossovers between the two services included issues of domestic violence and adult abuse. More and more children were living with elderly parents, creating more opportunities for abuse.

2.5 Serious incidents were referred to multidisciplinary services.

2.6 The work programmes of the two boards were similar, giving opportunities for cross fertilisation, looking at possibilities of joint commissioning. A proposal to set up joint board to deal with issues in some areas was being investigated to find out what could best be joined up.

2.7 The current transition between the adult and children's areas was felt to be insufficiently robust. The Chair of the Adult Safeguarding Board was the lead for transition.

2.8 The enormous increase in the amount of activity highlights the importance of early activity, intervention and prevention. It was important to maintain effective integrated early intervention. The SPOE (Single Point of Entry) dealt with referrals and now only around 10% went onto children's social work.

2.9 The vast majority of abuse takes place in people's own homes. Mechanisms need to be in place to enable people to spot abuse to ensure constant vigilance. People need to be able to raise issues if they feel uncomfortable. An increase in referrals is fine if we are able to respond and get people to provide support.

2.10 National trends are on the increase but Enfield is already ahead, as it began to work on the issues over 4 years ago.

2.11 The quality of the services provided in nursing/care homes is also important. The sector struggles to attract and retain high quality staff.

2.12 The work that we do in Enfield is a model of best practice in London, but we need to maintain our vigilance.

2.13 The Adult Safeguarding Board is looking to review their membership, once the new government guidance is in place and they are looking to invite Healthwatch to provide a representative on the board.

2.14 Enfield also provides a team of quality checkers and a dignity panel to oversee these issues.

AGREED to note the progress being made in protecting vulnerable adults and children in the borough, as set out in the annual reports from the Safeguarding Children Board and the Safeguarding Adults Board.

8
SUB BOARD UPDATES

1. Health Improvement Partnership Board

The Board received a report updating them on the work of the Health Improvement Partnership Board:

1.1 Presentation of the Report

Allison Duggal, Consultant in Public Health, presented the report to the Board, highlighting the following:

- Two versions of the Annual Public Health Report had just been published: an abridged summary as well as a more detailed report. The reports detail the work being carried out to tackle health inequalities across the borough.

- Enfield's report has synergies with the Better Health for London Report.

- Public Health has recently produced some GP and locality based profiles to help inform commissioning decisions. Ward profiles are also being put together.

- On the 17 November 2014 a Child Poverty Conference will be held, showcasing the work being done to tackle child poverty. From this an action plan will be put together to mitigate the effects of poverty as well as to minimise the intergenerational effects.

- A poster campaign is being run to raise awareness of the need for adults to cut down on salt intake to reduce hypertension and heart disease.

- Public Health have had a successful engagement with four local mosques to raise awareness of health issues such as diabetes.

- They have worked closely with CCG colleagues providing advice and intelligence to feed into health care strategies.

- Pathway redesign has been prioritised for long term conditions including musculoskeletal, diabetes, cardiology and respiratory.

- 12 independent funding requests had been received since April 2014.

- The Pharmaceutical Needs Assessment Steering Group is making process on producing the pharmaceutical needs assessment. A report will be bought to the Board later in the year.

- A report on tobacco use in the Turkish Community has highlighted the fact that 50% of 11-25 year olds use tobacco and 37% of respondents use shisha. Many are unaware of the risks. Public Health will be running focus groups to enable targeted interventions.
- Quarter 1 figures for health checks will be available at the end of the month and will be included in the next report.

- A universal BCG vaccination programme is being introduced across London. Flu planning and immunisations are in place and the Ebola outbreak is being kept under review.

1.2 Questions/Comments

1.2.1 Members praised the quality and user friendliness of the Annual Public Health Report.

1.2.2 The GP profiles were welcomed and it was hoped that they would provide a qualitative step forward in planning for the future needs.

1.2.3 Concern was expressed about the situation where NHS England has the control over GP budgets. It was felt that it would be more appropriate for the local CCG to control this area.

1.2.4 The CCG was pleased to work in partnership with public health. At one time a Turkish speaking officer had been employed to work with the Turkish community to help people give up smoking. This has had excellent results.

1.2.5 It was suggested that it would be helpful to have the papers in advance for the Child Poverty Conference.

1.2.6 The suggestion was made that there should be more collaborative work included in the full report. More emphasis needed to be placed on what can make the difference in tackling health inequalities and also the wider socio economic determinants of health. Getting people into work was most important, but this was something that would take time and could not happen in the short term. Focussing on how commissioners and health workers can make a difference in these areas would be helpful.

1.2.7 More information was also required on how the work being done linked into the Health and Wellbeing Strategy and whether this was working.

AGREED to note the contents of the report.

2. Joint Commissioning Sub Board Update

The Board received an update report on the work of the Joint Commissioning Board.

2.1 Presentation of the Report

Bindi Nagra (Assistant Director - Health, Housing and Adult Social Care - Strategy and Resources) presented the report to the Board, highlighting the following:

- The submission on the Better Care Fund took place on 19 September 2014.

- A response to the Care Act 2014 was submitted and we are now waiting for the regulations to be published. We have already fed in to the commissioning approaches including market engagement and market management.

2.2 Questions/Comments

2.2.1 The Older People's Assessment Units at Chase Farm and North Middlesex Hospital were both set up at the same time on the same basis but have developed differently. Both have strengths: at Chase Farm more social support has been given and at North Middlesex there has been more emphasis on geriatrician issues. Following discussion at the Integrated Care Board, it is being proposed that both units are kept but that they should be managed jointly as one service. There are plans to re-provide the centre as part of the redevelopment of Chase Farm. Liz Wise advised that they would be re-commissioned.

2.2.2 It was felt to be important to keep both units running as both different approaches were needed. More work was required to work out how the services could be integrated, based on the needs of the older people who access them.

2.2.3 Concern was expressed about the shortage of funding for the Enfield Warm Households Programme. Discussions on this were continuing and it was possible that a one off grant could be found to keep the project going for another year, but there was no dedicated funding stream. The Over 50's Forum had recently held a very successful keeping warm event.

2.2.4 Members were encouraged to support the Best Breakfast Campaign for Carers, taking place on the following day, which aimed to stress the value of eating breakfast.

AGREED

1. To note the contents of the report and its appendix.

2. To note that the Chair of the Health and Wellbeing Board, the Leader of the Council and the Chair of the Clinical Commissioning Group signed off the Better Care Fund paper on 19 September 2014.

3. Primary Care Improvement Sub Group Update

The Board received the report updating them on the work to date to implement the Primary Care Strategy.

3.1 Presentation of the Report

Dr Mo Abedi, Chair of the Enfield CCG, presented the report to the Board highlighting the following:

- The underlying aims of the Primary Care Strategy are integration, enhancing and improving health outcomes, access, patient experience and quality.

- Work is continuing on developing the GP networks. Two pan Enfield provider organisations have been established.

- As part of the locality commissioning agenda the 4 GP networks are meeting together targeting special measures: in accident and emergency, prescribing, administration of over 65's and referrals. The plan is to make good use of data and to target innovative measures.

- The 5 North Central London Boroughs have made a joint expression of interest to carry out joint commissioning arrangements from November 2014. This has been judged as being "ready soon". NCL will have a shared risk pool of £2m. The five boroughs will continue working with NHS England to progress the co-commissioning of services. It was hoped to achieve full delegated responsibility for primary care from April 2016.

- Work is continuing on developing primary care premises. The new Ordnance Road practice will be discussed further in the development session.

3.2 Questions/Comments

3.2.1 Ray James welcomed the co-commissioning initiative which he saw as crucial to the wellbeing of the community. It was suggested that the Board write to NHS England in support of the proposals.

3.2.2 Shahed Ahmad reported on the Ebola Outbreak. He said that so far the majority of cases were in West Africa and it was most important to support health care in that region. Brittain, France and the USA had sent support and there had been a good response to the call for volunteers.

3.2.3 At the national level emergency preparations were in place. Public Health in local government has an assurance role and to make sure that staff are adequately prepared.

3.2.4 There was some concern that the dissemination of information to GPs was patchy in some areas. This would be passed on to NHS England. A local planning exercise would be taking place next week and any gaps discovered would be followed up. The equipment needed, apart from face visors, was that which would be normally held by a GP practice.

AGREED

1. To note the contents of the report.

2. To write a letter on behalf of the board, to NHS England in support of the co-commissioning proposals.

9
MINUTES OF THE MEETING HELD ON 17 JULY 2014

The minutes of the meeting held on 17 July 2014 were received and agreed as a correct record.

10
DATES OF FUTURE MEETINGS

The Board noted the dates agreed for future meetings:

- Thursday 11 December 2014
- Thursday 12 February 2015
- Tuesday 14 April 2015

The Board noted the dates agreed for development sessions:

- Thursday 13 November 2014
- Thursday 22 January 2015
- Thursday 12 March 2015